

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

256016

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND:
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 26010

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
MYRTLE A. AFFELDT						9-7-85				11:35 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNER 24-HRS	
Female		White		July 4 1899		86		MONTHS DAYS		HOURS MIN.	
YRS											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH MD.			
Maryland		U.S.A.		<input checked="" type="checkbox"/>		<input type="checkbox"/>		Howard County			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Columbia		Howard County Gen. Hosp		Homemaker		Domestic					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Maryland		Howard		Columbia		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		10819 Harriet Dr. 21044			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		ADDRESS				
Charles				Albaugh	Emma		6296 Cedar Ln.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Columbus, Mo. 21044					
No		218-05-3296		Mary Clarkson		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		minutes					
				Cardiorespiratory arrest		upper. 1 hour					
				Cardiogenic shock		months					
				Congestive Cardiomyopathy / Valvular Cardiopat.		years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY			
22a. I certify that (I) (this hospital) attended the deceased from 9/7 1985 to 7/7 1985, that (I) (we) lost saw the deceased alive on 9/7 1985, and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Stephen A. Valentini MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/7/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Stephen A. Valentini MD		Howard County General Hospital									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 10 Sept 85		23c. NAME OF CEMETERY OR CREMATORIAL Crest Haven Mem. Gdn. Marr. & Hs. Howard		23d. LOCATION CITY OR TOWN		COUNTY			
Burial											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Slack Funeral Home		Ellicott City, Md 21042		10/10/85		Lisa Davidson-Pendall					

310265



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1-
FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH26011
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>HARRY</i>	MIDDLE <i>STEWART</i>	LAST <i>ANDERSON</i>	2a. DATE KNOWN OF DEATH ESTIMATED MATED	MONTH <input checked="" type="checkbox"/> 9	DAY <input type="checkbox"/> 24	YEAR <input type="checkbox"/> 1985	2b. HOUR <input type="checkbox"/> M			
3. SEX <i>Male</i>	4. RACE <i>Caucasian</i>	5. DATE OF BIRTH MONTH <i>3</i>	DAY <i>14</i>	YEAR <i>1894</i>	6. AGE (IN YEARS) LAST BIRTHDAY YRS. <i>89</i>	IF UNDER 1 YR. MONTHS <input type="checkbox"/>	IF UNDER 24 HRS. DAYS <input type="checkbox"/>	HOURS <input type="checkbox"/>	MIN <input type="checkbox"/>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Howard County</i>			20. DATE MONTH <i>9</i>	DAY <i>24</i>	YEAR <i>1985</i>	20. HOUR <i>11:35 PM</i>
10. CITY OR TOWN OF DEATH <i>Elkridge</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>5948 Hunt Club Rd.</i>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>retired</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <i>Maryland</i>		13b. COUNTY <i>Howard</i>	13c. CITY OR TOWN <i>Elkridge</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>5948 Hunt Club Rd., 21227</i>					
14. FATHER'S NAME FIRST <i>Harry</i>		MIDDLE <i></i>	LAST <i>Anderson</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Ida</i>		MIDDLE <i>M.</i>	LAST <i>Phelps</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>705 09 1545</i>		17. INFORMANT <i>Elizabeth M. Anderson</i>		ADDRESS <i>5948 Hunt Club Rd.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>Metastatic carcinoma of the colon.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Thomas F. Herbert</i>		TITLE (SPECIFY) M.D.		Deputy		MEDICAL EXAMINER						
EXAMINER'S NAME (TYPE OR PRINT) <i>Thomas F. Herbert, MD</i>		ADDRESS <i>Ellicott City, Md 21043</i>		DATE SIGNED <i>9-24-85</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE <i>9/27/85</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Meadowridge Mem. Park</i>		23d. LOCATION CITY OR TOWN <i>Elkridge</i>		COUNTY	STATE			
24. FUNERAL DIRECTOR NAME <i>Gary L. Kaufman</i>		ADDRESS <i>5695 Main St., Elkridge, Md. 21227</i>		25a. DATE REC'D. BY REGISTRAR <i>SEP 26 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Jane K. Johnson-Pendleton</i>						

PROJECTS



280076

Film G608 item 13e, 17
FOR per F.H. Call
REGISTRAR 10/4/85 rjaSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 6 0 1 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
<i>MERCER M BARNETTE</i>						9 28 85				10 15 AM		
3 SEX			4 RACE	5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)					
<i>M</i>			<i>White</i>	MONTH	DAY	YEAR	IF UNDER 1 YEAR			IF UNDER 24 HRS		
7a BIRTHPLACE STATE OR FOREIGN COUNTRY			7b CITIZEN OF WHAT COUNTRY?			8	12	25	MONTHS	DAYS	HOURS	MIN
<i>Virginia</i>			<i>U.S.A.</i>			<input checked="" type="checkbox"/> MARRIED	<input type="checkbox"/> NEVER MARRIED	<input type="checkbox"/>	YRS.			
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
<i>Columbia, Md</i>			<i>Howard County General</i>			<i>Retired Printer</i>			<i>U.S. Gov't.</i>			
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS				
<i>Maryland</i>			<i>Howard</i>	<i>Ellicott City</i>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<i>11310 Frederick Rd</i>			11310		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
FIRST <i>Mercer M Barnette Sr.</i>			MIDDLE	LAST	FIRST <i>Ethel</i>	MIDDLE	LAST <i>Horton</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
Yes			WW 11			227 22 4840			Charlotte Barnette 11310 Frederick Rd. 21043			11310
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <i>Respiratory Failure</i>												15 hours
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) <i>Small Cell CA of Lung - Extensive Stage</i>									9 months
			DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Anemia, Cerebral metastases, Liver Failure</i>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>January 19 85</i> , to <i>September 19 85</i> , that (I) (we) last saw the deceased alive on <i>Sept 27 1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Jon K. Minford</i>			DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Jon K. Minford</i>			22e. ADDRESS <i>10806 Hickory Ridge Rd, Columbia</i>									
23a. BURIAL, CREMATION, REMOVAL (SPEC) <i>Burial</i>			23b. DATE <i>Oct 2, 1985</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Meadowridge</i>			23d. LOCATION CITY OR TOWN			
									COUNTY <i>Howard</i>	STATE <i>Maryland</i>		
24. FUNERAL DIRECTOR NAME <i>Harry H Witzke</i>			ADDRESS <i>4112 Columbia Rd Ellicott City</i>			25a. DATE REC'D. BY REGISTRAR <i>OCT 3 1985</i>			25b. REGISTRAR'S SIGNATURE <i>Jeanne Gardner Pendleton</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be detached and should be buried within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

07002



259139

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reprinted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be left in this position until 72 hours after death.

MEDICAL CERTIFICATION

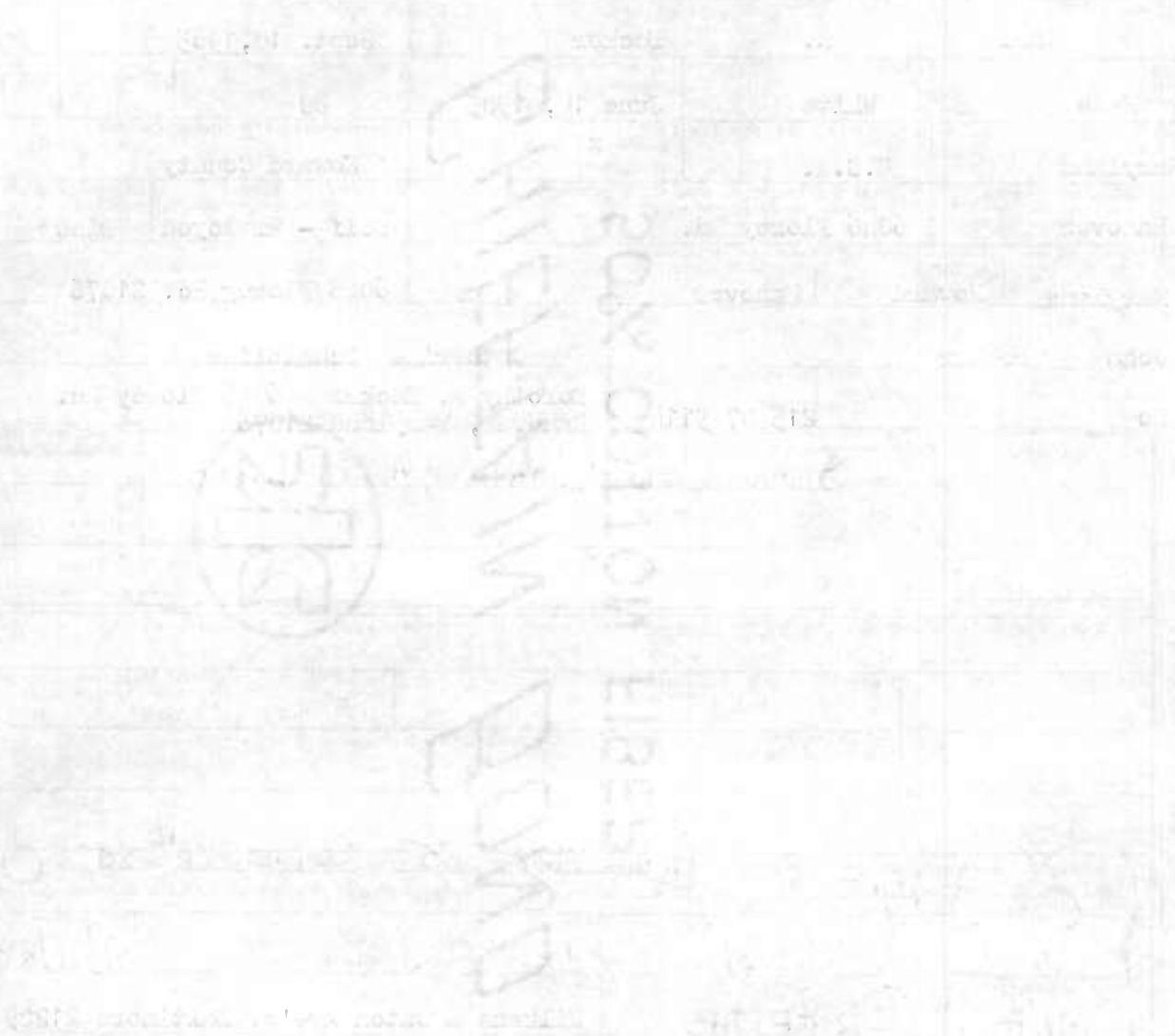
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8526013

REG. NO.

I. DECEASED NAME (TYPE OR PRINT) Carl A. Becker			LAST	2a. DATE OF DEATH Sept. 10, 1985	MONTH	DAY	YEAR	2b. HOUR M		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 14, 1905	6. AGE (IN YEARS LAST BIRTHDAY) 80 IF UNDER 1 YEAR MONTHS YRS. DAYS	IF UNDERR 24 HRS. HOURS 80 MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Howard County							
10. CITY OR TOWN OF DEATH Hanover	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6046 Florey Rd.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self - Employed								
13a. STATE Maryland	13b. COUNTY Howard	13c. CITY OR TOWN Hanover	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 6046 Florey Rd. 21076						
14. FATHER'S NAME FIRST John	MIDDLE Becker	LAST	15. MOTHER'S MAIDEN NAME FIRST Catherine Schnebleine	MIDDLE LAST						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215 07 9114	17. INFORMANT Dorothy E. Becker	ADDRESS 6046 Florey Rd. Hanover, Maryland 21076							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SMALL CELL CARCINOMA OF LUNG			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT HOME <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) APRIL 27 1985	21f. LOCATION (CITY OR TOWN) LINE#	CITY OR TOWN		COUNTY		STATE			
22. I certify that (1) this physician attended the deceased from APRIL 21 1985 , and that (2) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did not view the body after death.)										
23. SIGNATURE DIANA L. GRIFFITHS			DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 9/11/85					
24. PHYSICIAN'S NAME (TYPE OR PRINT) DIANA L. GRIFFITHS			22e. ADDRESS Wilkens & Caton Ave's. Baltimore 21229							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Sept. 13, 1985	23c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery	23d. LOCATION CITY OR TOWN Baltimore, Maryland 21229	CITY OR TOWN		COUNTY		STATE		
24. FUNERAL DIRECTOR NAME Gary L. Kaufman Funeral Home, Elkridge 21227	ADDRESS	25a. DATE REC'D. BY REGISTRAR SEP 13 1985	25b. REGISTRAR'S SIGNATURE Julia Davidson-Renolds							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 18 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 5 2 6 0 1 4	REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2d. HOUR:			
<i>BETTY S. BENDER</i>						<i>9-20-85</i>						<i>4:25 PM</i>			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.			
<i>Female</i>		<i>white</i>		<i>8 21 10</i>			<i>75</i>			<i>YRS.</i>	<i>MONTHS</i>	<i>DAYS</i>	<i>HOURS</i>	<i>MIN.</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
<i>NEW YORK</i>		<i>U. S. A.</i>					<i>HOWARD</i>								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
<i>COLUMBIA</i>		<i>LORIEN N. H.</i>			<i>Housewife</i>			<i>Own Home</i>							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			21046		
<i>Maryland</i>		<i>Howard</i>		<i>Columbia</i>						<i>6334 Cedar Lane</i>					
14. FATHER'S NAME FIRST		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST					
<i>Juda</i>				<i>Aarowsky</i>	<i>Fanny</i>					<i>Ruben</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			18. ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
<i>No</i>		<i>060-20-8632</i>		<i>Philip A. Bender</i>			<i>7414 Weatherworn Way, Columbia, Maryland 21046</i>			<i>MINUTES</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Arrest</i>															
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Pneumonia</i>												<i>36 hrs</i>			
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Alzheimers disease</i>												<i>>3 yrs</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>ASCD, COPD.</i>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
					<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>9/15/85</i> , to <i>9/20/85</i> , that (I) (we) last saw the deceased alive on <i>9/15/85</i> , and that (I) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) did (did not) view the body after death.															
22b. SIGNATURE <i>Melvin J. Kordon MD</i>		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>9/20/85</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Melvin J. KORDON MD</i>		22e. ADDRESS <i>2000 Century Plaza Columbia Md 21046</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>9/22/1985</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Judean Memorial Gardens</i>			23d. LOCATION CITY <i>Olney, Montgomery, Md.</i>								
24. FUNERAL DIRECTOR <i>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.</i>								25a. DATE REC'D. BY REGISTRAR <i>SEP 25 1985</i>			25b. REGISTRAR'S SIGNATURE <i>Julie Davidson Pendleton</i>				
BP _____															
DHMH - 16 60M 7/84 (VRA 15, 4)															

some common types

and their variability

259140

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 26015

REG. NO.

1 - STATE REGISTRAR ROSE A. CAPPELLI

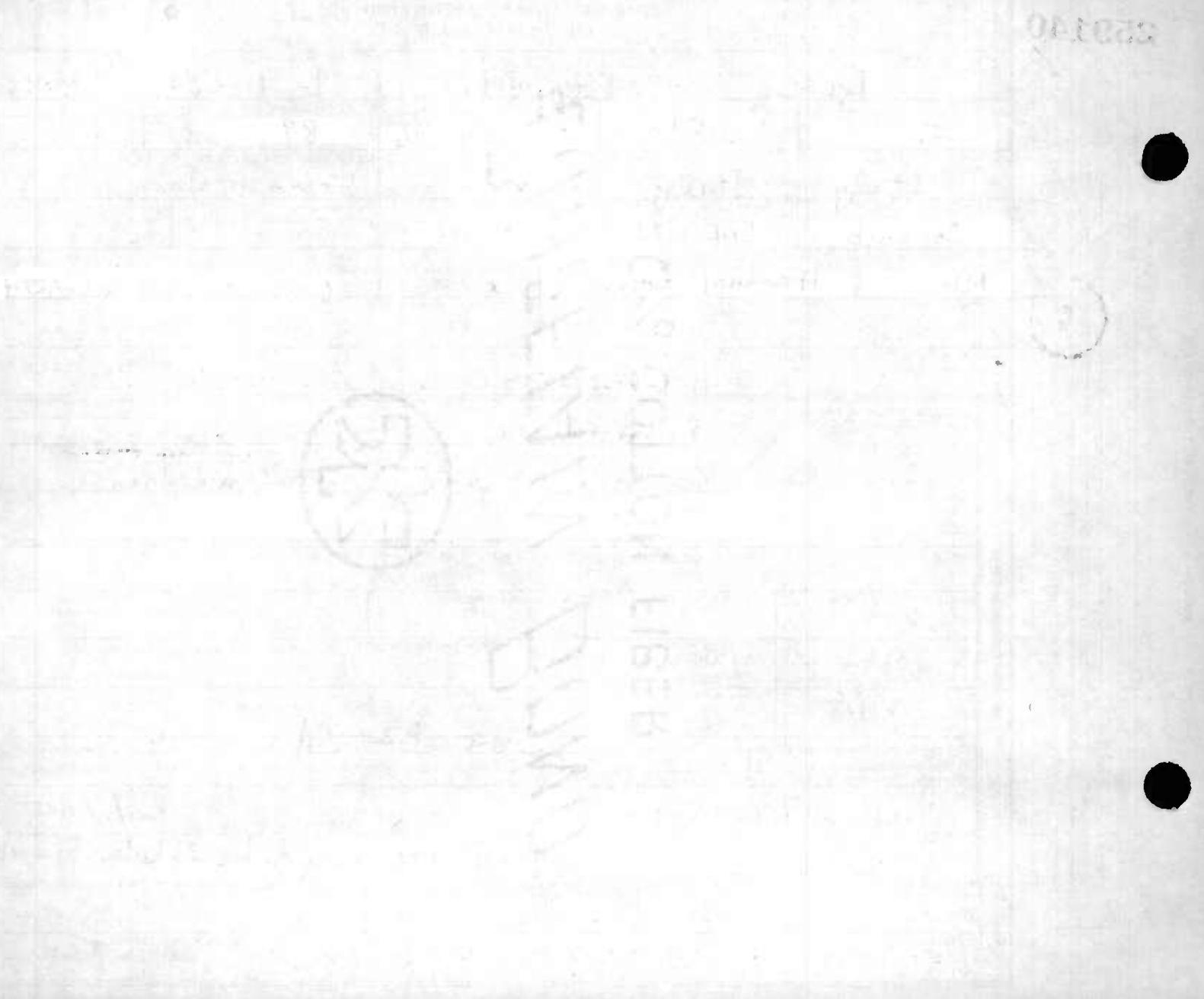
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	MONTH	DAY	YEAR	2b. HOUR
Rose			A.	Cappelli		9	11	85		49. M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS	7. IF UNDER 24 HRS HOURS MIN.				
Female	white	April 24, 1893			92					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Italy	Italy				Howard Co.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Columbia	Lorien Nursing Home			Housewife			Own Home			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE	Apt. 403			
Maryland	Howard	Columbia				6150 Foreland Garth	21045			
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST			
Philip		Abruzzo	Rosa				D'Alberto			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No	101-24-0225	Joseph A. Cappelli			5232 W. Running Brook Columbia, Md. 21044					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failure										
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Organic Brain syndrome										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).										
19a. DATE OF OPERATION NA	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE DEGREE										
William Flowers, M.D. DEGREE										
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			22f. DATE SIGNED				
Flowers, Wm			10302 Hickory Ridge Rd Columbia MD			9/11/85				
23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE 9/13/85	23c. NAME OF CEMETERY OR CREMATORIUM St. Raymond's Cemetery			23d. LOCATION CITY OR TOWN	23e. COUNTY	23f. STATE			
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A. 5555 Twin Knolls Road, Columbia, Md. 21045			25a. DATE REC'D. BY REGISTRAR SEP 13 1985			25b. REGISTRAR'S SIGNATURE John Pendleton				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed (filled in by the funeral director), page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

041025



259099

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 6 0 1 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	26 HOUR	
JANE			E	DEGRAFFT		9	7	85	0305 AM		
3. SEX			4 RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
F			CAUC	MONTH	DAY	YEAR	68	IF UNDER 24 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Illinois			U.S.A.					HOWARD			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
COLUMBIA			HOWARD COUNTY GENERAL HOSP			Housewife			MD.		
13a. STATE			13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
MD			HOWARD	ELLIOTT CITY					3449 TYLER COURT 21043		
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME					
Adolph A Bischoff						Annie Shipley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
NO			706 18 2612 A			Raymond D. DeGrafft			3449 Tyler Court 21043		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a) Acute myocardial infarction								
			DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD								
			DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Alzheimer's disease											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AI WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2 Sept 19 85 to 2 Sept 19 85, that (I) (we) last saw the deceased alive on 7 Sept 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. PHYSICIAN'S NAME (TYPE OR PRINT)			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			DATE SIGNED		
Stephen Zamel M.D.									9/7/85		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN			COUNTY	STATE	
Cremation			Sept 11, 1985	Westview Memorial Pk		Catonsville			Balto., Md.		
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Harry H Witzke 4112 Columbia Rd			Ellicott City			SEP 11 1985			M. L. Witzke		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies Hayes 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/83

(VRA 15, 4)

ecology



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 5 2 6 0 1 /							
										REG. NO.							
1 - STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT)			FIRST Charles		MIDDLE B.		LAST Doll		2a DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
		<i>Charles</i>							<i>Doll</i>		<i>9-18-85</i>				<i>7:02 PM</i>		
3 SEX		4 RACE			5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
<i>Male</i>		<i>White</i>			<i>Dec. 18, 1913</i>			<i>71</i>			MONTHS	DAYS	HOURS	MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?			8			9 BALTIMORE CITY OR COUNTY OF DEATH			YRS						
<i>Pennsylvania</i>		<i>U. S. A.</i>			<i>MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></i>			<i>Howard County</i>									
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			12a USUAL OCCUPATION			12b KIND OF BUSINESS OR (TYPE OF WORK FOR MOST OF WORKING DAY)			MD.						
<i>Columbia</i>		<i>Howard County General Hosp.</i>						<i>Salesman</i>			<i>Self-Employed</i>						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										21104							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		2300 Marriottsville Rd.							
<i>Md.</i>		<i>Howard</i>		<i>Marriottsville</i>		<i>NO <input checked="" type="checkbox"/></i>											
14. FATHER'S NAME		FIRST ?	MIDDLE ?	LAST Doll	15. MOTHER'S MAIDEN NAME		FIRST Lula	MIDDLE ?	LAST Md.								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
<i>No</i>		<i>212-14-3142</i>		<i>Howard County, Marriottsville, Ethel E. Doll-2300 Marriottsville Rd.</i>		<i>21104</i>		<i>months</i>									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Renal Failure</i>																	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atherosclerosis, Atherosclerosis</i>										<i>months</i>							
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Acute Tubular Necrosis</i>										<i>months</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>myocardial infection.</i>																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
					<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept. 18 1985</i> , to <i>Sept. 18 1985</i> , that (I) (we) last saw the deceased alive on <i>Sept. 18 1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.																	
22b. SIGNATURE <i>J. L. Lewis</i> DEGREE										22c. DATE SIGNED <i>9-18-85</i>							
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>																	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <i>10802 Hickory Ridge, Columbia, Md.</i>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>9/23/85</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Crest Lawn Memorial Gardens-Howard Cnty, Md.</i>		23d. LOCATION CITY OR TOWN		CITY OR TOWN		COUNTY	STATE						
24 FUNERAL DIRECTOR <i>Sterling Funeral Estate, P. A.</i> ADDRESS <i>736 Edmondson Ave.; Catonsville, Md. 21228</i>						25a. DATE REC'D. BY REGISTRAR <i>SEP 24 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Gilia Kaiden-Pender</i>									

280c2S

affectionately

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it will be filed with the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 through 3 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner, must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REGISTRATION
26 U 18

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	REG. NO.									
EDWARD F FEUERNHERD						Sep 14, 1985									
3. SEX		4. RACE		5. DATE OF BIRTH		6. DATE OF DEATH	MONTH	DAY	YEAR	26 HOUR					
M		CAUC.		1	10	21	Sep	14	1985	205 PM					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (INCLUDES LAST BIRTHDAY)	10. UNDER 1 YEAR BIRTH MONTH	11. DATES MONTH	12. UNDER 24 HRS. HOURS						
Md.		U. S. A.				64	YRS.								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Columbia		Howard County Gen'l. Hospital		Bricklayer-Contractor											
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. STATE									
						Md.	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE					
						Howard	Columbia	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	#21045	5639 Oakland Mills Rd.					
						14. FATHER'S NAME									
						Adolph	Gustave	Catherine	Grady						
						FIRST	MIDDLE	LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)						16b. SOCIAL SECURITY NO.				17. INFORMANT	ADDRESS				
Yes						214-18-9970				Doris L. Feuerherd	Md. #21045				
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						BRONCHOPNEUMONIA				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DUE TO, OR AS A CONSEQUENCE OF (b) ESOPHAGEAL + GASTRIC OBSTRUCTION						6 WKS.									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last															
DUE TO, OR AS A CONSEQUENCE OF (c) ESOPHAGUS						8-10 MO.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) HYPERTENSIVE DISEASE; P.V.C.s															
19a. DATE OF OPERATION 3/1/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ADENOCARCINOMA OF ESOPHAGUS				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from March 1985 , to Sep 14 1985 , shot (I) (we) lost saw the deceased alive on Sep 14 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Richard A. Currie MD		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-4-85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD A. CURRIE		22e. ADDRESS 2 Twin Knolls N. Columbia Md 21045													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE 9-7-85		23c. NAME OF CEMETERY OR CREMATORIAL Loudon Pk. Cem.		23d. LOCATION CITY OR TOWN Balto		COUNTY		STATE Md.					
24. FUNERAL DIRECTOR G. Truman Schwab		25a. DATE REC'D. BY REGISTRAR SEP 5 1985		25b. REGISTRAR'S SIGNATURE Jean Davidson-Randall											
#21229															

PARIS



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

214091

35 26019

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	26. HOUR	
				Clara	J. M.	Freeburger	7	26	85	5:35 P.M.		
3. SEX				4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR			IF UNDER 24 HRS		
				Female	White	7 22 17	68	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?	8	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Howard Co. MD.					
10. CITY OR TOWN OF DEATH Columbia				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard Co. General			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY Biscuit Co.		
13a. STATE Md				13b. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 1137 W. Hamburg St. + 10321230		
14. FATHER'S NAME First Middle Last Edgar J. Tracy				15. MOTHER'S MAIDEN NAME Dora			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			17. INFORMANT ADDRESS James A. Warren 1137 W. Hamburg St. 21230		
18. CAUSE OF DEATH (Enter only one cause per line for 1(a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				Cardio-respiratory Failure						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.				DUE TO, OR AS A CONSEQUENCE OF (b) Sebaceous, Possible pneumonia						2 days		
				DUE TO, OR AS A CONSEQUENCE OF (c) Cut Cell Cancer of lung with metastasis to Brain. 8 months								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>5/19/85</u> , to <u>7/26/85</u> , that (I) (we) last saw the deceased alive on <u>7/26/85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>John C. L.</u>			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7/26/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS Howard Co. General Hosp.									
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial			23b. DATE 7-30-1985 Cedar Hill Cemetery			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Baltimore 21223			23d. LOCATION CITY OR TOWN Baltimore County State Md.			
24. FUNERAL DIRECTOR NAME John C. L.			25a. DATE REC'D. BY REGISTRAR JUL 30 1985			25b. REGISTRAR'S SIGNATURE Julie Davidson-Randall						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

reigned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the original papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the hospital or attending physician.

with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be informed.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 5 2 6 0 2 0

1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
I. DECEASED NAME FIRST George J. J. MIDDLE Gabana LAST E. S. A. D. N. A.				Jul 30 85				2:55 A.M.	
3. SEX Male		4. RACE caucasian		5. DATE OF BIRTH MONTH 9 DAY 12 YEAR 15-		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County		MD.	
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) clerk		12b. KIND OF BUSINESS OR INDUSTRY Int. Harvester			
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Elkridge		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 21227 6620 Washington Blvd. Lot #7	
14. FATHER'S NAME FIRST George		MIDDLE Gabana		LAST		15. MOTHER'S MAIDEN NAME FIRST Mary		MIDDLE unknown	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 181-12-0634A		17. INFORMANT Hilda M. Gabana		ADDRESS 6620 Washington Blvd. Elkridge, Md. 21227			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Adeno Carcinoma Lung & Liver metastasis									
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Emphysema, Chronic Alcoholism									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 6-21, 1985, to 7-30, 1985, that (I) (we) last saw the deceased alive on 7-30, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE P V Kanani		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22d. DATE SIGNED 7-30-85			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) KANANI		22f. ADDRESS Howard County General Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIES) burial		23b. DATE 8/1/85		23c. NAME OF CEMETERY OR CREMATORIAL Meadowridge Cemetery		23d. LOCATION CITY OR TOWN Elkridge, Howard MD.		23e. COUNTY STATE	
24. FUNERAL DIRECTOR NAME Gary L. Kaufman		ADDRESS 5695 Main St., Elkridge, Md 21227		25a. DATE REC'D. BY REGISTRAR JUL 31 1985		25b. REGISTRAR'S SIGNATURE Gene L. Kaufman			
DHMH - 16 50M 4/83 (VRA 15, 4)									

COOKIES

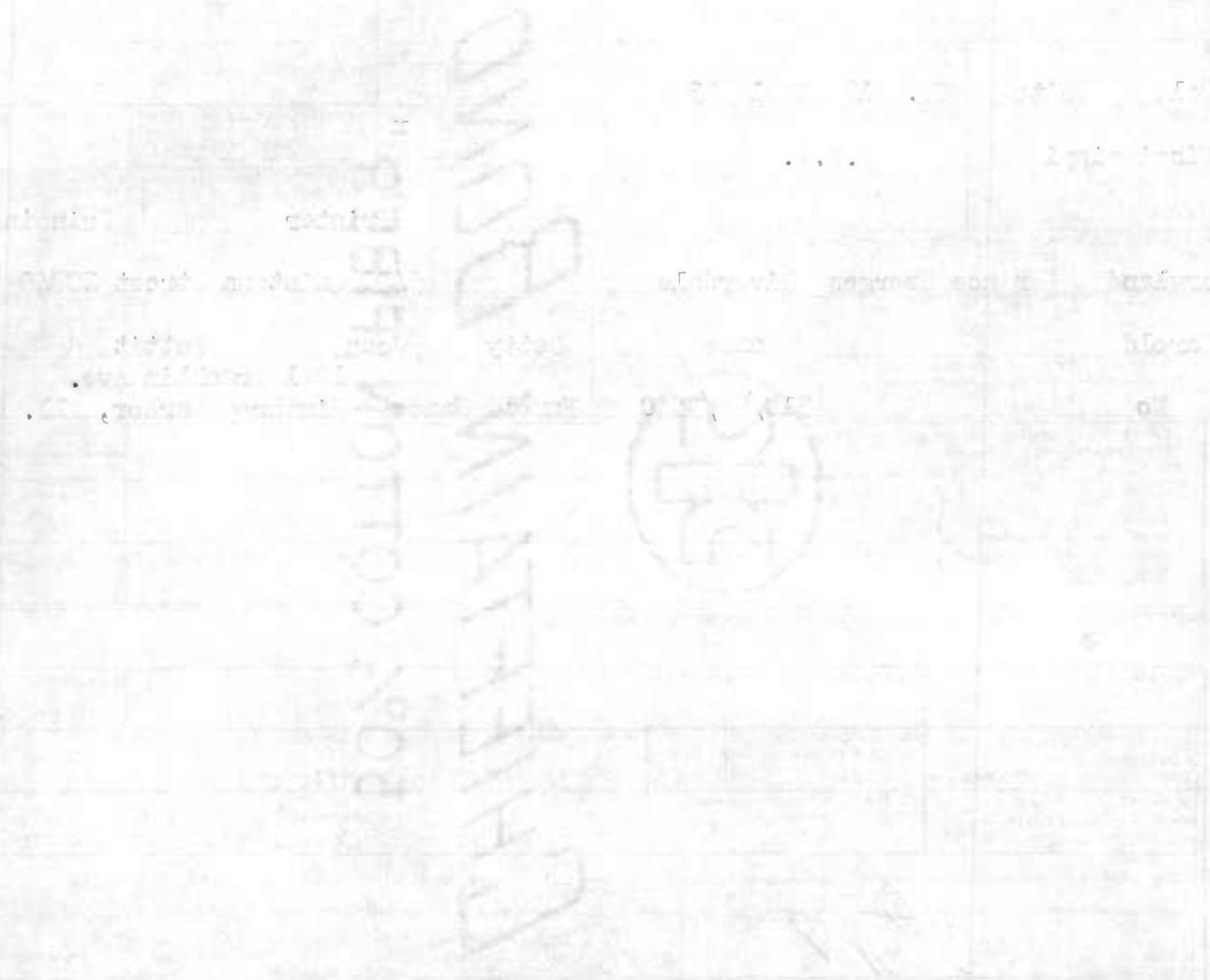
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE RECORDED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENICIL IN ITEM 18. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3 RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, Cremation, or Removal.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 26021				
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>			MONTH DAY YEAR 9 219 85	2b HOUR M			
			Ronny Dale Haase													
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD MONTH DAY YEAR 9 3 19 85			2d HOUR 11:50 M	
Male		White		OCT. 13 1961		23 yrs.										
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Howard County							
Mississippi			U.S.A.													
10. CITY OR TOWN OF DEATH Laurel			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Savage Quarry-Off Gorman Road			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Printer			12b KIND OF BUSINESS OR INDUSTRY Printing							
13a STATE Maryland			13b COUNTY Prince Georges		13c. CITY OR TOWN Riverdale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5400 Quintana Street 20840							
14. FATHER'S NAME FIRST Harold			MIDDLE		LAST Haase		15. MOTHER'S MAIDEN NAME FIRST Betty		MIDDLE Jean		Pettit					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b SOCIAL SECURITY NO. 310/72/3540			17. INFORMANT Harold Haase			1221 ADDRESS Franklin Ave. Winthrop Harbor, IL 60096							
No																
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <i>9108</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (a) <i>Drowning</i> DUE TO, OR AS A CONSEQUENCE OF																
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.																
(b) _____ DUE TO, OR AS A CONSEQUENCE OF																
(c) _____																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1-a																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 9 219 85			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>Subject drowned while swimming</i>										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) quarry			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>Savage Quarry off Gorman Rd, Laurel, Howard, MD.</i>										
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>[Signature]</i>												TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.												DATE SIGNED 9/3/85				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 107 SEPT 85			23c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery			23d. LOCATION CITY OR TOWN Zion			COUNTY		STATE		
24. FUNERAL DIRECTOR NAME Bo B. BOX 268 SLACK FUNERAL HOME						EILICOTT CITY, MD 21043			25a. DATE REC'D BY REGISTRAR SEP 10 1985			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				
DHMH - 17 (VR A15 ME (5))																

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and executed, it may be used for burial permit. Then please remove carbon papers. If you need a burial permit, file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "injury, or other traumatic event, the medical certification section must be completed.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 26022

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR										2b. HOUR									
		Laura			E. Nalvorseth			Sept 21 85				6 ⁰⁰ PM									
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS										
F		Cauc.		MONTH 4 DAY 04 YEAR 94			91		YRS		MONTHS DAYS HOURS MIN.										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH														
Minnesota, USA		U.S.A					Howard County MD.														
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Columbia, md		Lorian Nursing Home										Retired Saleslady									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE													
Md		Howard		Clarksville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13615 Highland Rd 21029													
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME													
Isaac Pehrson								Ellen Svenson													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS		21029											
Unknown				560-05-9510		Mrs Jane Eddy		13615 Highland Rd Clarksville													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Citriac Arrest</u>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <u>Citriac congestive heart failure</u>																					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Citriac arrhythmia brain syndrome</u>																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)																	
		P.M. 19																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE											
22a. I certify that (1) (the hospital) attended the deceased from now to the time of death on <u>Sept 21 85</u> , and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body, enter death.)				4/21 1983 to 9/21 1985																	
22b. SIGNATURE <u>Eugene Jackson, m.d.</u>		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <u>9/21/85</u>											
22e. ADDRESS <u>5340 Ten Oaks Ln, Clarksville, m.d.</u>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation										23b. DATE Sept 23'85		23c. NAME OF CEMETERY OR CREMATORIAL Westview Memorial Pk		23d. LOCATION CITY OR TOWN Catonsville		COUNTY Balto., Maryland		STATE	
24. FUNERAL DIRECTOR NAME <u>Henry H. Witke</u> ADDRESS <u>4112 Columbia Rd Ellicott City, MD.</u>		25a. DATE REC'D. BY REGISTRAR SEP 27 1985										25b. REGISTERED BY <u>John H. Mandel</u>									

123



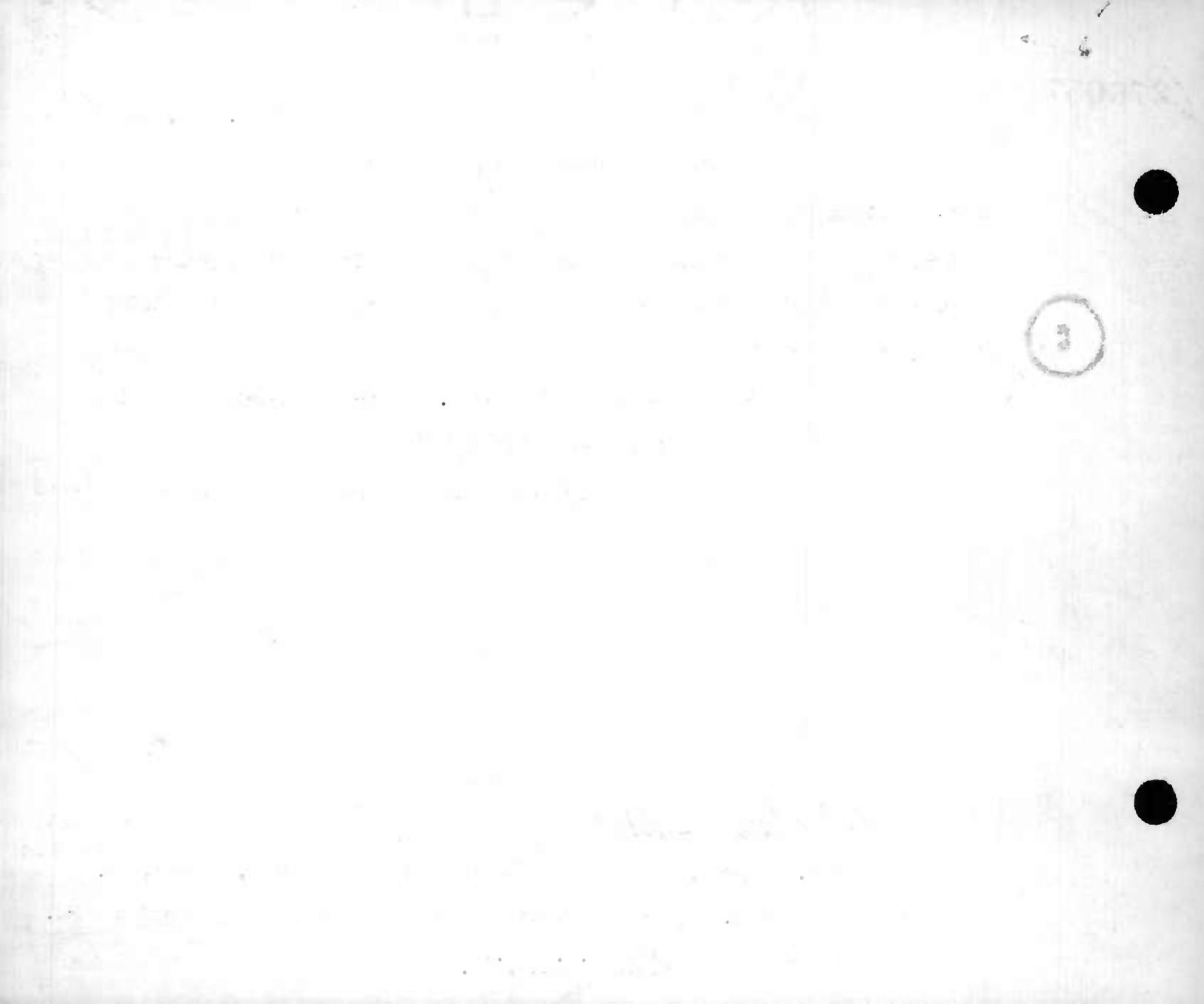
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and retained by the hospital or attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 3 should be detached for use as the burial permit. Please return this page to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if there is any injury, or other traumatic event, it must be notified to one:

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3526023		
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR SEPT. 27, 1985							2b. HOUR 8:57 A.M.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST PHOEBE	MIDDLE MARIE	LAST HANBACK							
3. SEX Female			4. RACE White		5. DATE OF BIRTH MONTH July DAY 20, 1906 YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 79			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina			7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Howard			MD.	
10 CITY OR TOWN OF DEATH Columbia			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lorien Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Switchboard Operator			12b. KIND OF BUSINESS OR INDUSTRY Chinese Embassy				
13a. STATE Maryland			13b. COUNTY Prince Georges		13c. CITY OR TOWN Laurel			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 16108 Kent Road 20707	
14. FATHER'S NAME Zebulon Emmanuel			MIDDLE	LAST Jarman	15. MOTHER'S MAIDEN NAME Anna			MIDDLE Louise	LAST Newman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A			16b. SOCIAL SECURITY NO. N/A		17. INFORMANT Phoebe H. Tebbs - daughter - (same as 13e)			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY ARREST												
DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRO VASCULAR ACCIDENT 1mo												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (this hospital) attended the deceased from 6/19/85 to 9/27/85, that (we) last saw the deceased alive on 9/20/85 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did not) view the body after death.												
22b. SIGNATURE Gregory A. Compton, MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9-27-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gregory A. Compton, MD			22e. ADDRESS SUITE 221 14201 Laurel Park Drive, Laurel, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept. 30, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Trinity Memorial		23d. LOCATION Waldorf		23e. STAFF PHYSICIAN Charles Md.			
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home			11800 N.H. Ave. Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR OCT 1 1985			25b. REGISTRAR'S SIGNATURE Leslie Davidson Pendee				
DHMH - 16 50M 4/83 (VRA 15, 4)												



260015

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 26024

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
NORMA			RHEA	HATFIELD		9-11-85				9:05 P.M.		
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		Cauc	MONTH	DAY	YEAR	83	MONTHS	YEARS	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8							
MARYLAND		U.S.A.			MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Columbia		Lorien Nursing Home			HOMEMAKER			HOME				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE			
MD		Baltimore				YES <input type="checkbox"/>	NO <input type="checkbox"/>		215 Oaklee Village 21229			
14. FATHER'S NAME		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. ADDRESS			17. INFORMANT		
WILLIAM			STEHLING	CAROLINE			WARKIN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
NO		212-22-5760			M/M WILLIAM MARSHACK			424 CRISFIELD DR. 21009				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>												
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinomatosis</u>												
DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastatic adenocarcinoma to bone from breast</u>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Severe coronary artery disease + CHF @ Euphysence</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (we) attended the deceased from so we the deceased alive on <u>9-15-85</u> 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (we) did not view the body after death.		22b. SIGNATURE <u>Melvin J. Kordon MD</u>			22c. DEGREE			22d. DATE SIGNED <u>9-11-85</u>				
22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22f. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Melvin J. Kordon MD</u>			22g. ADDRESS <u>2000 Century Plaza Columbia MD 21044</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE BURIAL 09-14-85		23c. NAME OF CEMETERY OR CREMATORIAL LAKE VIEW MEMORIAL PARK			23d. LOCATION CITY OR TOWN SYKESVILLE		COUNTY CARROLL	STATE MARYLAND		
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.		ADDRESS 21229 4107 WILKENS AVENUE			25a. DATE REC'D. BY REGISTRAR SEP 13 1985			25b. REGISTRAR'S SIGNATURE <u>Jane Hubbard</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director's office, it should be delivered for use as the burial permit. Then please remove carbon paper. Pages 1 & 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 21 is marked as

210025



260057

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 26 925

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				FIRST <u>Clara</u>	MIDDLE <u>B.</u>	LAST <u>Hay</u>	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
							<u>Sept 8 1985</u>				<u>6 PM</u>
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR	
<u>F</u>		<u>Cauc.</u>		MONTH <u>Aug</u>	DAY <u>14</u>	YEAR <u>1896</u>	89			MONTHS	DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
<u>Pennsylvania</u>		<u>U.S.A.</u>					<u>Norward</u>				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
<u>Columbia</u>		<u>Lorien Nursing Home</u>					<u>Housewife</u>				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <u>MD</u>		13b. COUNTY <u>A. A</u>		13c. CITY OR TOWN <u>Linthicum</u>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <u>104 Michael Ave 21090</u>	
14. MOTHER'S NAME FIRST <u>Frank</u>		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST <u>Dively</u>			MIDDLE	LAST	<u>Musser</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>173-18-7751</u>		17. INFORMANT			ADDRESS			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				<u>Betty Forror</u>			<u>104 Michael Ave 21090</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST.</u>											
DUE TO, OR AS A CONSEQUENCE OF <u>CARDIAC ARREST</u>											
{ (b) <u>ARTERIOSCLEROTIC HEART DISEASE WITH</u>											
{ DUE TO, OR AS A CONSEQUENCE OF (c) <u>CHRONIC OBSTRUCTIVE LUNG DISEASE</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>CHRONIC URINARY TRACT INFECTION, SIP & Hip Hemorrhaphy.</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
—		—					—		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			—			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21b. TIME OF INJURY P.M. 19		21c. HOW INJURY OCCURRED			—			—			
21d. INJURY OCCURRED VEHICLE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on		3-12-84		19 84			to		9-8-85		19 85
above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Sudhir D. Patel</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>9/8/85</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>SUDHIR D. PATEL.</u>		22e. ADDRESS <u>LORIEN NURSING HOME</u>					<u>Columbia Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial		23b. DATE <u>9-11-85</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Berlin IOOF</u>			23d. LOCATION CITY OR TOWN		COUNTY	STATE	
24. FUNERAL DIRECTOR NAME <u>Mac Nabb Funeral Home</u>		ADDRESS <u>301 Frederick Rd</u>		25a. DATE REC'D. BY REGISTRAR <u>SEP 13 1985</u>			25b. REGISTRAR'S SIGNATURE <u>Randall</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be resigned by the Hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and witnessed by a Notary Public, it should be retained for use on the burial permit. Then please remove certificate pages 1-4 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, no medical certificate is required.

DHMH - 16 60M 7/84
(VRA 15, 4)

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 26020

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR		
<i>ISAAC R. JACKSON SR.</i>						9	25	8	1985	7:30 AM		
3. SEX		14 RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)						
<i>M</i>		<i>NEGRO BLACK</i>	MONTH	DAY	YEAR	IF UNDER 1 YEAR		IF UNDER 24 HRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8	MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	YRS.		
<i>NEW YORK USA</i>		<i>USA</i>				9. BALTIMORE CITY OR COUNTY OF DEATH						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY		
<i>Columbia Md</i>		<i>Howard Co Gen Hospital</i>			<i>MERCHANT MARINE const</i>							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET ADDRESS / ZIP CODE	
<i>Md</i>		<i>Howard</i>		<i>Columbia</i>							<i>1150 Foreland Garth 21045</i>	
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME							
<i>CLAUDIUS A</i>				<i>JACKSON</i>	FIRST	<i>ELLA</i>	MIDDLE	LAST			<i>TIMBERS</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS					
<i>NO</i>		<i>717-07-4582</i>			<i>WIFE</i>							
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of Stomach</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. (b) _____												
DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Debt over Person</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>9/24/85</i> to <i>9/25/85</i> , that (I) (we) lost saw the deceased alive on <i>9/24/85</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (not) view the body after death.												
22b. SIGNATURE <i>J S Seals</i>		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J. S. Seals</i>		22e. ADDRESS <i>1150 Forel North Col. 43</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>9/28/85</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>West View Mem. Park</i>			23d. LOCATION CITY OR TOWN <i>Baltimore, Maryland</i>		COUNTY	STATE		
24. FUNERAL DIRECTOR NAME <i>Law Funeral Home</i>		ADDRESS <i>4611 Park Heights Ave. @1215</i>			25a. DATE REC'D. BY REGISTRAR <i>SEP 30 1985</i>			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it may be filed in the funeral director's office. Then please remove carbon paper. Please do not file this certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 21 is marked on Item 18 there is any injury, or other traumatic event, the medical examiner must be notified.

3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician it should be detached for use as the burial transit permit. Then please remove carbon copy and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

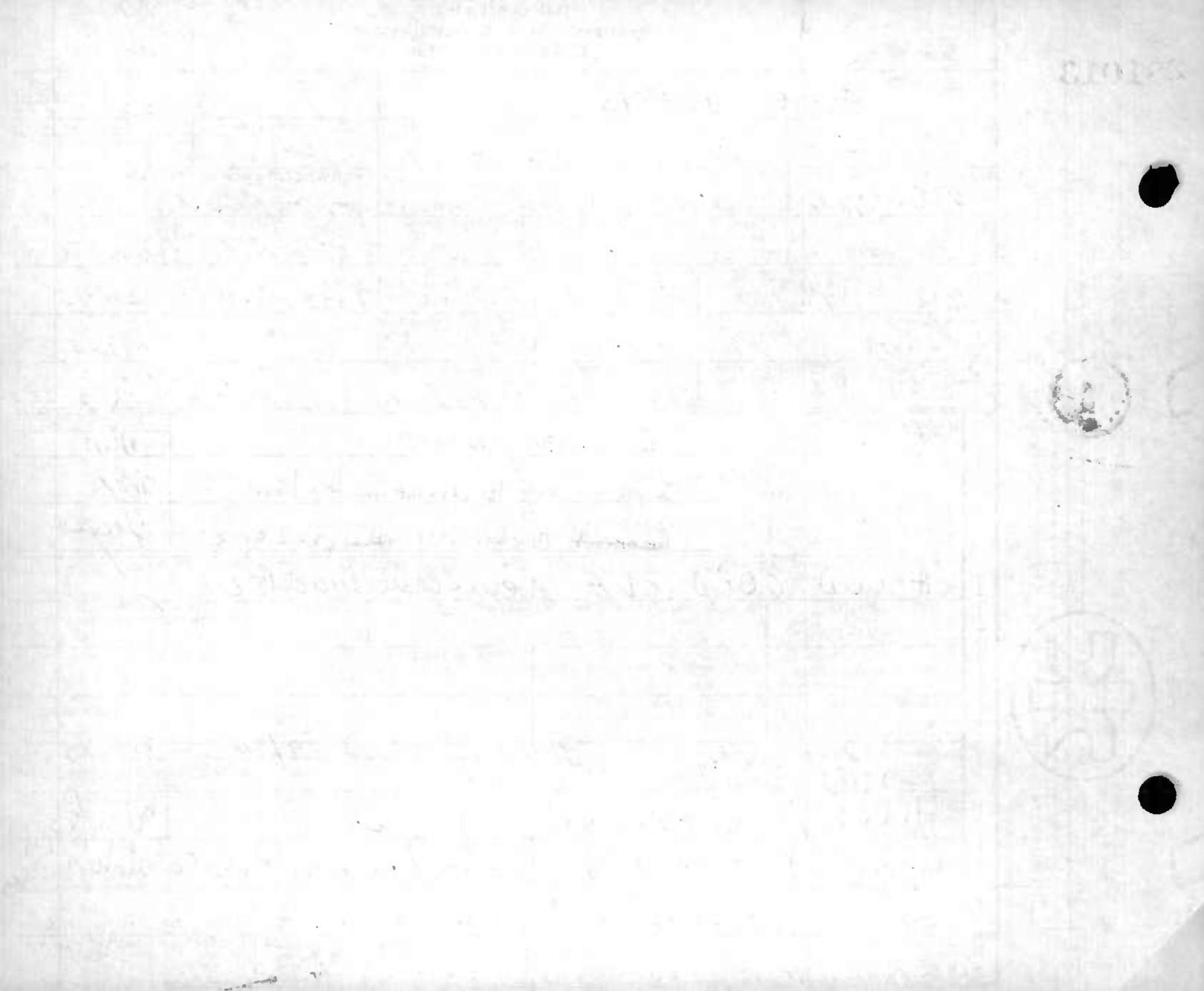
MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

5 26 82 1

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
ELSIE JOHNS						9/30/85				7:35 A.M.	
3. SEX			4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)				7b. IF UNDER 1 YEAR		
F			W	MONTH DAY YEAR	78				MONTHS	YEARS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH		
VIRGINIA			USA			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Howard Co. 21044 MD		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
COLUMBIA			Howard County General Hospital			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 8532 Main St. 21043		
13c. STATE			13b. COUNTY	13c. CITY OR TOWN	15. MOTHER'S MAIDEN NAME			ADDRESS			
MD.			HOWARD	COLUMBIA	CALLIE			211 S. Pulaski St. Baltimore, Md 21223			
14. FATHER'S NAME			FIRST	MIDDLE	LAST	LAST			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
CHARLES					HICKS	HICKS			min		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT					
NO			226-30-9755			Lothir Zellmer					
18. CAUSE OF DEATH (Enter only one cause per line for 18, 1b1, and 1c1) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest											
DUE TO, OR AS A CONSEQUENCE OF (b) sepsis 2nd to urine infection days											
DUE TO, OR AS A CONSEQUENCE OF (c) benedict parkinsons disease years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b ASCD, COPD, CVA no evidence bladder disease											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>8/27</u> 19 <u>85</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (Did) (Did not) view the body after death.											
22b. SIGNATURE <u>Merle Kunkel</u>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9/30/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Merle Kunkel			22e. ADDRESS 2000 Century Plaza Columbia MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 02 OCT 85			23c. NAME OF CEMETERY OR CREMATORIAL Good Samaritan Com.			23d. LOCATION CITY OR TOWN Ellicott City Howard MD		
24. FUNERAL DIRECTOR NAME Shack Funeral Home			ADDRESS Box 248 Ellicott City, MD 21043			25a. DATE REC'D. BY REGISTRAR OCT 4 1985			25b. REGISTRAR'S SIGNATURE		



263126

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 2. PAGE 2 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 3 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												26028			
1- STATE REGISTRAR ANN L. JOHNSON									REG. NO.						
I. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Ann</i>	MIDDLE <i>L</i>	LAST <i>Johnson</i>	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH <i>9</i>	DAY <i>12</i>	YEAR <i>1985</i>	2b. HOUR <i>11 PM</i>			
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>	5. DATE OF BIRTH MONTH <i>February</i>	DAY <i>5, 1911</i>	YEAR <i>74 yrs.</i>	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS <i>0</i>	IF UNDER 24 HRS. DAYS <i>0</i>	HOURS <i>0</i>	MIN <i>0</i>	2c. DATE PRONOUNCED DEAD	MONTH <i>9</i>	DAY <i>12</i>	YEAR <i>1985</i>	2d. HOUR <i>11 PM</i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Connecticut</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Howard County</i>					
10. CITY OR TOWN OF DEATH <i>Dayton</i>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>5115 Green Bridge Road</i>			12a. USUAL RESIDENCE (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Clerk</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Telephone Co.</i>						
10. STATE <i>Connecticut</i>			13b. COUNTY <i>New Haven</i>	13c. CITY OR TOWN <i>Hamden</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/>			13e. STREET ADDRESS <i>Peck Lane</i>			13f. APARTMENT NUMBER <i>06518</i>				
14. FATHER'S NAME FIRST <i>George</i>			MIDDLE <i></i>	LAST <i>Lockery</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Mary</i>			MIDDLE <i>Ellen</i>	LAST <i>McGarty</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. <i>045-10-3870</i>			17. INFORMANT <i>Mrs. Linda A. Greco</i>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-respiratory arrest</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Cardio-vascular Disease</i>			DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner												and in my opinion			
ACTUAL SIGNATURE <i>Thomas F. Herbert</i>			M.D.			TITLE (SPECIFY) <i>Deputy</i>			MEDICAL EXAMINER			DATE SIGNED <i>9-12-85</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>Thomas F. Herbert, M.D.</i>			ADDRESS <i>Ellicott City, Md 21043</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>9/16/85</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Mary's Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Mount Carmel New Haven</i>			COUNTY	STATE		
24. FUNERAL DIRECTOR <i>Terry M. & Russell C. Witzke Funeral Homes P.A.</i>			25a. DATE REC'D. BY REGISTRAR <i>SEP 18 1985</i>			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>									
5555 Twin Knolls Road, Columbia, Md. 21045															
20M 4/82															
DHMH - 17 (VR A15 ME (5))															



RECORDED IN THE LIBRARY OF CONGRESS

273049

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Please initial and sign page 1 and have it witnessed by another health professional. After the death certificate is signed, it should be sent to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												85	26029		
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST			2d. DATE OF DEATH			MONTH	DAY	YEAR	2d. HOUR	
DEWITT					CLINTON JOHNSON			9			21	85	2021	M	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		# UNDER 24 HRS			
MALE		WHITE		- 10 16 23			61			YEARS	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE <small>COUNTRY</small>		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Howard County MD					
TENNESSEE		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
COLUMBIA		HOWARD COUNTY GENERAL										Mechanic			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
MD		HOWARD		ELLIOTT CITY			YES <input type="checkbox"/> NO <input type="checkbox"/>			4575 MANOR LANE 21043					
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
William		Edgar	J.	Johnson	Effie			4575 Manor Ln.							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.										Ms. Audrey Johnson ELLIOTT CITY, MD 21043			
YES		213-2-1884													
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		19. DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		19. DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
20a. DATE OF OPERATION			20b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/21, 1985, to 9/21, 1985, that (I) (we) last saw the deceased alive on 9/21, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														22c. DATE SIGNED 9/21/85	
22b. SIGNATURE Edward B. Bolgiano Jr.														DEGREE	
22c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED 9/21/85												
22e. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD B. BOLGIANO			22f. ADDRESS UNIV MARYLAND HOSPITAL												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 9-25-85			23c. NAME OF CEMETERY OR CREMATORIAL Crestview Mem. Cem. Inc. at Ellicott City, Howard, Md.			23d. LOCATION CITY OR TOWN		COUNTY				
Burial			9-25-85			Crestview Mem. Cem. Inc. at Ellicott City, Howard, Md.			Ellicott City, Howard, Md.						
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR SEP 26 1985			25b. REGISTRAR'S SIGNATURE Wilson Pendleton						
Slack Funeral Home			Ellicott City, Md. 21043												

1857-1862

Items 18-22a 10/30/85 mba F-3608 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 26030

274004

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM BM-3. RETAIN A PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER FORM. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	W MONTH DAY YEAR	2b. HOUR
SEUNG Jik KIM						<input type="checkbox"/>	9 25 19 85	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	MONTH DAY YEAR	2d HOUR
Male	Oriental	Sept. 22, 17	67 yrs.	MONTHS DAYS	HOURS MIN.	<input type="checkbox"/>	9 25 19 85	3:55 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Korea		Korea					Howard County	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Ellicott City		10282 Burleigh Cottage Court			Clerk		Gift Shop	
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Ellicott City		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 10282 Burleigh Cottage Court 21043	
14. FATHER'S NAME FIRST Sea		MIDDLE Pok		LAST Kim		15. MOTHER'S MAIDEN NAME FIRST Bok		MIDDLE Nyo LAST Kim
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-04-7355			17. INFORMANT Kwang Nam Kim		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____						ADDRESS 10282 Burleigh Cottage Ct. Ellicott City, MD. 21043		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? Body Only <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
23. ACTUAL SIGNATURE EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 23b. DATE Burial 9/27/85 23c. NAME OF CEMETERY OR CREMATORY Meadow Ridge Memorial Park								
23d. LOCATION CITY OR TOWN Elkridge COUNTY Howard STATE MD.								
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, Maryland 21133								
23a. DATE REC'D. BY REGISTRAR 23b. REGISTRAR'S SIGNATURE SEP 27 1985 Julia Loring-Bryers								
25. DHMH - 17 (VR A15 ME (5))								

20045

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262036

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from page 2 and 3 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, medical examiner must be notified of death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 85126031
1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR
I. DECEASED NAME FIRST MIDDLE LAST		9 14 85			3A M
WILLIAM J. LINK					
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR	
				9 23 91	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.	
				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.	
13a. STATE Maryland		13b. COUNTY Carroll		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		13c. CITY OR TOWN Sykesville		13e. STREET ADDRESS / ZIP CODE 108 Heritage Lane 21784	
14. FATHER'S NAME George Link				15. MOTHER'S MAIDEN NAME Carrie Dietz	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. WW1		17. INFORMANT ADDRESS Mr. William Link, Jr. 108 Heritage Lane	
		218-03-6421			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Sepsis					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (b)			
		DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE ANTONIO FATO		DEGREE		22c. DATE SIGNED 9/14/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANTONIO FATO		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			
		22e. ADDRESS 9504 Old Georgetown Rd Bethesda, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/17/85		23c. NAME OF CEMETERY OR CREMATORIAL Meadowridge Cemetery	
				23d. LOCATION CITY OR TOWN Dorsey	
24. FUNERAL DIRECTOR NAME Ambrose, Inc.		ADDRESS 1328 Sulphur Spring Road		25a. DATE REC'D. BY REGISTRAR SEP 16 1985	
				25b. REGISTRAR'S SIGNATURE	

360582



268002

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please do it.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Please sign and file within 72 hours after death.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

1. DECEASED NAME			FIRST <i>Frank</i>	MIDDLE	LAST <i>MANAGO Sr.</i>	2a. DATE OF DEATH	MONTH 9	DAY 19	YEAR 85	2b. HOUR 108
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH 10 DAY 12 YEAR 12	6. AGE (IN YEARS LAST BIRTHDAY) 72	IF UNDER 1 YEAR MONTHS YRS	IF UNDER 24 HRS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOUTH CAROLINA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY							
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labor	12b. KIND OF BUSINESS OR INDUSTRY State Roads Comm.					
13a. STATE MARYLAND	13b. COUNTY Howard	13c. CITY OR TOWN Jessup	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 8690 PINE ROAD 20794						
14. FATHER'S NAME SANDY MANAGO	FIRST SANDY	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME LOTTIE BYRD	MIDDLE	LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO (S. NO. OR UNKNOWN)	16b. SOCIAL SECURITY NO. 597-03-7126	17. INFORMANT Adnette Manago 8690 Pine Road	ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>mesothelioma</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>h</i>		
DUE TO, OR AS A CONSEQUENCE OF (c)								<i>h</i>		
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY YES <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>Home</i>	21f. LOCATION STREET <i>Scot St</i>	CITY OR TOWN <i>Bethesda</i>	COUNTY <i>Montgomery</i>	STATE <i>Maryland</i>					
22a. I certify that (I) (this hospital) attended and deceased from <i>Sept 19 1985</i> , 19 <i>85</i> , to <i>Sept 25 1985</i> , 19 <i>85</i> , that (II) (we) lost <i>saw the deceased alive on above, (II) (we) (did) (did not) view the body after death.</i>										
22b. SIGNATURE <i>Martin D. Weitz</i>	DEGREE <i>MD</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN	STAFF <input type="checkbox"/>	22c. DATE SIGNED <i>9/19/85</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN D. WEITZ 7525 Greenway Ln. Dr. Greenbelt MD 20770	22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 9-24-85	23c. NAME OF CEMETERY OR CREMATORIAL MARYLAND NATIONAL	23d. LOCATION CITY OR TOWN LAUREL	COUNTY MARYLAND	STATE					
24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H 1101 E. NORTH AVENUE	ADDRESS	25a. DATE REC'D. BY REGISTRAR SEP 25 1985	25b. REGISTRAR'S SIGNATURE <i>John K. Johnson</i>							

300245

20 CONCERNED SUPPORTERS

273051

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 5 2 6 0 3 3

1 - STATE
REGISTRAR

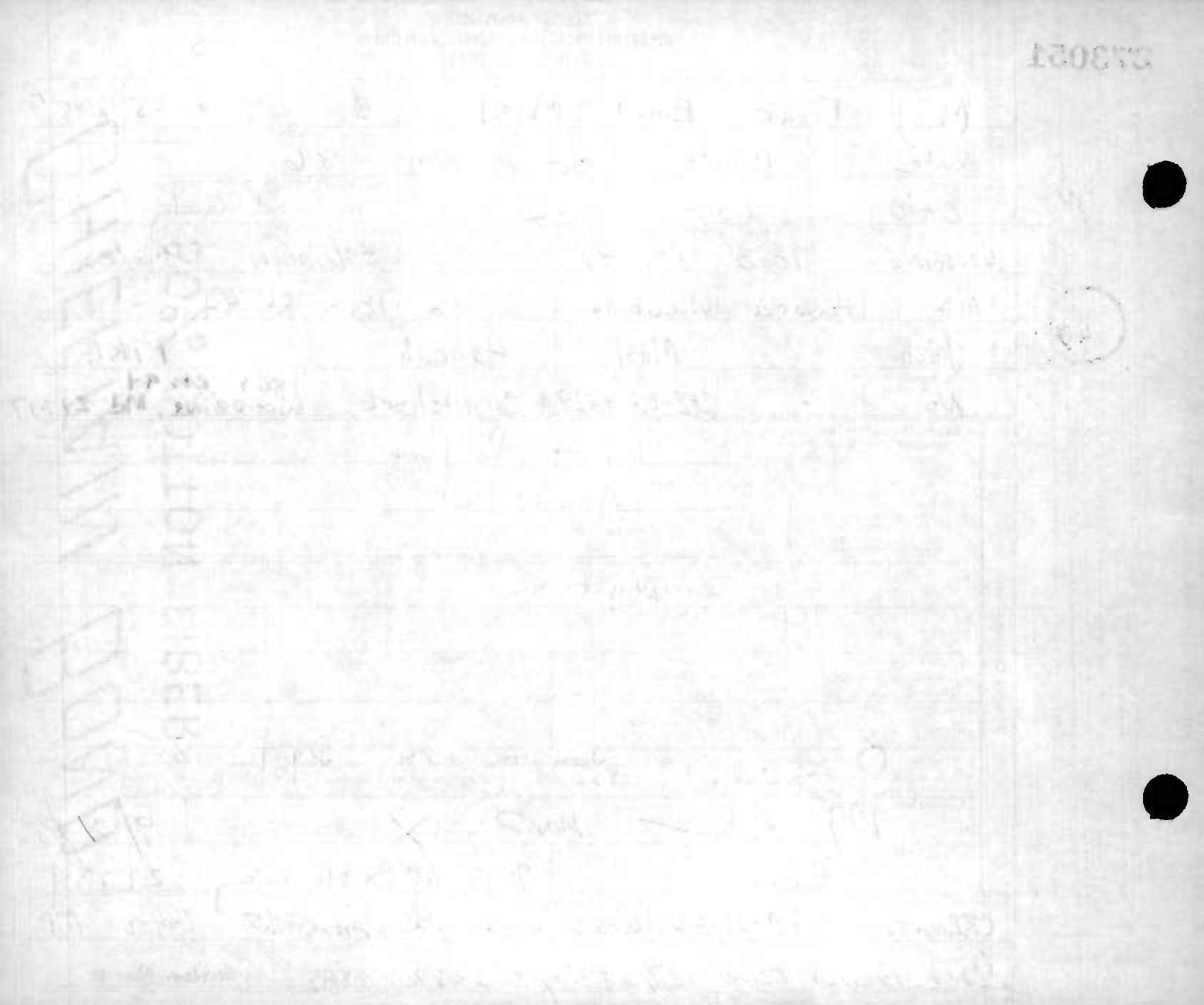
1 DEC		2 ID NAME (TYPE)	3 FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
			Frank Emil Masl			9	9	-21-85	8:45 A	
3 SE		4 RACE	5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)	7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN.		
		male	White Oct 10 1898		86					
7a BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		MD.		
OHIO		U.S.A.				Howard County				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <small>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)</small>		12a USUAL OCCUPATION <small>(TYPE OF WORK FOR MOST OF WORKING LIFE)</small>		12b KIND OF BUSINESS OR INDUSTRY				
Woodbine		1868 Rt. 97		Salesman		Sales				
13a STATE MD.		13b COUNTY Howard	13c CITY OR TOWN Woodbine	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 1868 Rt. 94 21797				
14. FATHER'S NAME FIRST Jacob		MIDDLE	Middle Masl	15. MOTHER'S MAIDEN NAME FIRST Hannah		MIDDLE	PICK			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. -		17 INFORMANT 282-03-4329 Ms. Carol Velisek		ADDRESS 1868 Rt. 94 Woodbine, MD 21797		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
<p>18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) heart failure</p> <p>DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.</p> <p>DUE TO, OR AS A CONSEQUENCE OF (c)</p>										
<p>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a</p> <p>emphysema</p>										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>July 9</u> , 19 <u>85</u> , to <u>Jan 2</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>July 9</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did not view the body after death.										
22b. SIGNATURE <u>M. Peksa</u>		DEGREE <u>MP</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9/21/85</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>M. Peksa</u>		22e. ADDRESS <u>7098 Mt Beth Way 21784</u>								
23a. BURIAL, CREMATION, REMOVAL <u>CREMATION</u>		23b. DATE <u>9-23-85</u>		23c. NAME OF CEMETERY OR CREMATORIUM <u>Westview Mem. Pk. Corcoran</u>		23d. LOCATION CITY OR TOWN <u>Corcoran</u>		STATE <u>MD.</u>		
24 FUNERAL DIRECTOR NAME <u>Black Funeral Home</u>		ADDRESS <u>Elkton City MD 21042 SEP 26 1985</u>		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Ma Davidson-Pendleton</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be detached for use as the burial/transit permit. Hand write "24 hours after death" with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

54302T



263164

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.				
1. FOR STATE REGISTRAR			2d DATE OF DEATH MONTH DAY YEAR									2b HOUR				
4. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			9-15-85		645 A.M.		
MAY ELIZABETH MEYER																
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
FEMALE			WHITE			MONTH 5 - DAY 29 - YEAR 91			94			MONTHS		DAYS		
7a BIRTHPLACE COUNTRY			7b CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			YRS.	
ENGLAND			U.S.A.									HOWARD CO.			MD.	
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
COLUMBIA			LORIEN NURSING HOME									RET - NURSE			NURSING	
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			20708	
MD			PG. CO.			LAUREL						13600 BARNETT LN.				
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST	
JOSEPH						BAKER			MARY			ANN			EDWARDS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			16c. INFORMANT			16d. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
NO			265-54-96350			LOIS K. PARRISH (SAME AS #13)										
18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b, and 1c: PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST.															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE FAILURE - CARDIAC																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.																
DUE TO, OR AS A CONSEQUENCE OF (c) ANEMIA - TRANSIENT RENAL INFARCTION CALCIUM OF COLON																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from 7-2-1985 to 8-13-1985, that (I) (we) last saw the deceased alive on 8-13-1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did/did not view the body after death.															22c. DATE SIGNED 9-15-85	
22b. SIGNATURE H. Chambers						DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. Chambers						22e. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 9-18-1985			23c. NAME OF CEMETERY OR CREMATORIUM WASHINGTON NAT'L CEM. SHUTLAND PG. CO. MD.			23d. LOCATION CITY OR TOWN			COUNTY		STATE		
BURIAL																
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO.			ADDRESS RIVERDALE, MD.			25a. DATE REC'D. BY REGISTRAR SEP 18 1985			25b. REGISTRAR'S SIGNATURE John Chambers, Director							
BP _____																
DHMH - 16 60M 7/84 (VRA 15, 4)																

NOTING

(1)

4000 87 432

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

266053

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 85 26035	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			Roy ELMER Miser						9-16-85			12-20 PM	
3. SEX M			4. RACE W			5. DATE OF BIRTH MONTH DAY YEAR 3 10 14			6. AGE (IN YEARS LAST BIRTHDAY) 71			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tenn			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.				
10. CITY OR TOWN OF DEATH Columbia			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard City General			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter			12b. KIND OF BUSINESS OR INDUSTRY Union				
13a. STATE Md			13b. COUNTY Howard			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 7734 Washington Blvd.	
14. FATHER'S NAME FIRST Jesse			MIDDLE Lee			LAST Miser			15. MOTHER'S MAIDEN NAME FIRST Vernom			MIDDLE Mullins	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR OATES) --			17. INFORMANT LETA MISER			ADDRESS SAME AS 13E				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause if any. (b) Other chronic cardiovascular (c) disorder. Recent stroke.													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a SPUTTERING pneumonia implant													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 11-15-1984 to 11-24-1984 , that (I) (we) last saw the deceased alive on 11-14-1984 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED	
22b. SIGNATURE An Levy			22d. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) An Levy			22f. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (SPECIES) Burial			23b. DATE 9/19/85			23c. NAME OF CEMETERY OR CREMATORIAL MEADOWRIDGE MEM. PH.			23d. LOCATION CITY OR TOWN Baltimore			COUNTY	STATE
24. FUNERAL DIRECTOR NAME FLECK F.H. INC.			25a. ADDRESS Laural, MD 20707			25b. DATE REC'D. BY REGISTRAR SEP 10 1985			25b. REGISTRAR'S SIGNATURE RECEIVED				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed and witnessed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper from this page and attach it to the burial permit. This certificate is valid for 72 hours after death.

IMPORTANT: If Item 21 is marked "X", Item 18 shows a non-fatal injury, or other traumatic event, the medical examiner must be notified once.

268078

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

85 26036

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>EVA L. OmLOR</i>						<i>9 23 85</i>					
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 88		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
<i>FEMALE</i>			<i>Cauc.</i>		<i>08 30 97</i>						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>HOWARD</i>				
10. CITY OR TOWN OF DEATH <i>Columbia</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Howard Co. GENERAL</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOUSEWIFE</i>		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE <i>MD.</i>			13b. COUNTY <i>HOWARD</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>3202 Normandy Woods DR. 21073</i>				
14. FATHER'S NAME FIRST <i>JOHN</i>			MIDDLE <i>KURTZ</i>	LAST	15. MOTHER'S MAIDEN NAME FIRST <i>EMMA</i>		MIDDLE	LAST <i>QUINN</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>193-18-3814</i>		17. INFORMANT <i>JOSEPH omLOR</i>		ADDRESS <i>3202 Normandy Woods</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>pneumonia and congestive heart failure</i>											
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <i>malnutrition</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>9/18</i> , 19 <i>85</i> , to <i>9/23</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Dan Phillips</i> DEGREE											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>GARY Phillips</i>		22e. ADDRESS <i>1 Knoll North, Columbia Md.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>9/23/85</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>9/25/85</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>ST. EDWARDS</i>		23d. LOCATION CITY OR TOWN <i>SHANOKON</i>		COUNTY	STATE <i>PB.</i>		
24. FUNERAL DIRECTOR NAME <i>B. JABROWSKI 2818 E. BALTIMORE ST.</i>		25a. DATE REC'D. BY REGISTRAR <i>SEP 23 1985</i>		25b. REGISTRAR'S SIGNATURE							

270-405



280035

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

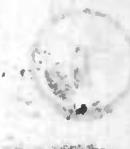
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 with the State Dept. of Health and Mental Hygiene prior to burial/cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3 5 2 6 0 3 1		
1. DECEASED NAME (TYPE OR PRINT)				FIRST <i>Edgar</i>	MIDDLE	LAST <i>OZOLS</i>	2a. DATE OF DEATH MONTH DAY YEAR <i>9-29-85</i>	MONTH <i>9</i>	DAY <i>29</i>	YEAR <i>85</i>	2b. HOUR <i>6:35 P.M.</i>	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>7 8 13</i>			6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		# UNDER 1 YEAR MONTHS DAYS		# UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Latvia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Howard County</i>			MD.		
10. CITY OR TOWN OF DEATH <i>Columbia</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Howard County General</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Manager/Display</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Clothing</i>					
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Howard</i>		13c. CITY OR TOWN <i>Columbia</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>9977 Cape Ann Drive 21046</i>				
14. FATHER'S NAME FIRST <i>(unknown)</i>				LAST <i>Ozols</i>			15. MOTHER'S MAIDEN NAME FIRST <i>Berta</i>		MIDDLE		LAST <i>(unknown)</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>042-26-2210</i>		16c. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive Left hemispheric stroke</i>			17. INFORMANT <i>Maria E. Ozols</i>			ADDRESS <i>Same as # 13</i>		
18. CAUSE OF DEATH (Enter only one cause per line for 10a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive Left hemispheric stroke</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>20 days.</i>		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)												
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>atherosclerotic vascular disease</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AI WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (the hospital) attended the deceased from <i>9-09-</i> , 19 <i>85</i> , to <i>9-29</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>9-29</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated below. I (we) did (did not) view the body after death.										22c. DATE SIGNED <i>9-29-85</i>		
22b. SIGNATURE <i>Danny A. Moore MD (Dr. J. Seal)</i>										DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Danny A. Moore</i>										22d. ADDRESS <i>2 Knoll North, Columbia MD.</i>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>10/1/85</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Westview Crematory</i>			23d. LOCATION CITY OR TOWN <i>Catonsville</i>		COUNTY	STATE <i>Maryland</i>		
24. FUNERAL DIRECTOR <i>Leroy M. & Russell C. Witzke Funeral Homes P.A.</i> 5555 Twin Knolls Road, Columbia, MD. 21045										25a. DATE REC'D. BY REGISTRAR <i>10/1/85</i>	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

220032



274061

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3 WHICH SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 4 AND 5 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

26038

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR
PETER			P.	PEACH		<input checked="" type="checkbox"/>				9 20 1985
3. SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	9c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	12d. HOUR
Male	White	May 16, 1957	28 yrs.			<input checked="" type="checkbox"/>				12:30 p.m.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			12e. KIND OF BUSINESS OR INDUSTRY
Maryland		U.S.A.					Howard County			MD
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. ADDRESS			
Ellicott City		yard - 3496 Church Rd.					3496 Church Rd 21043			
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Ellicott City		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS			
14. FATHER'S NAME Lawrence D Peach						15. MOTHER'S MAIDEN NAME Shirley				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. NO		17. INFORMANT ADDRESS		Lawrence D. Peach 3496 Church Rd 21043				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF		Shotgun wound of head								
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		Self-inflicted.				
12:05 M. 9-20- 1985										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE
		yard		3496 Church Rd., Ellicott City,		Howard,				MD
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE 										M.D. Assistant MEDICAL EXAMINER
EXAMINER'S NAME (TYPE OR PRINT)										DATE SIGNED
Ann M. Dixon, M.D.										9-21-85
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN				
Burial		Sept 23'85		Crestlawn		Howard				County Maryland State
24 FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. DATE REC'D. BY REGISTRAR				
Harry H Witzke		4112 Columbia Rd Ellicott City		SEP 27 1985						
DHMH - 17 (VR A15 ME (5))										

190100



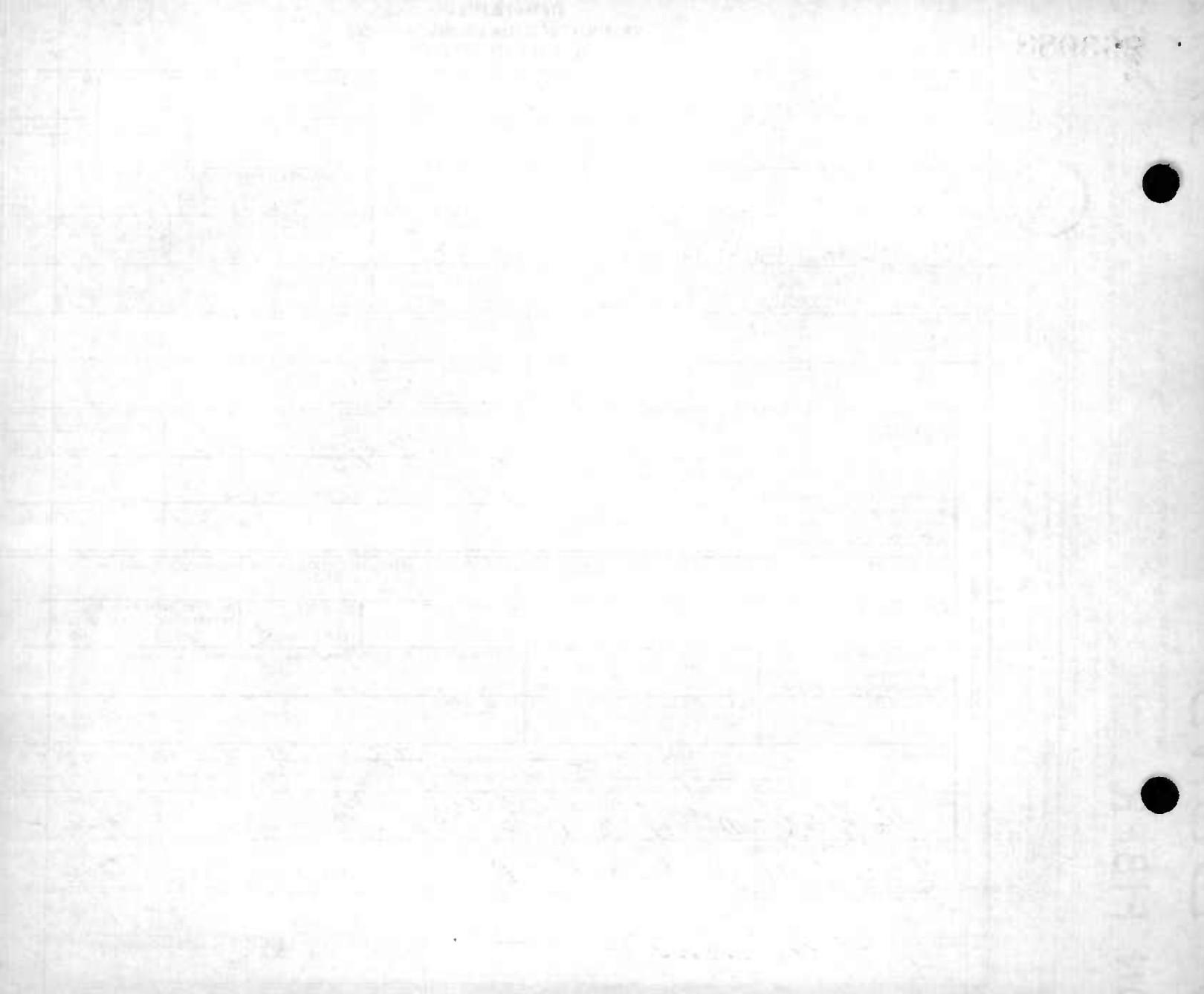
263088

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 3526039		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
James HOWARD Renshaw						SEPTEMBER 14, 1985						A M		
3. SEX <u>Male</u>			4. RACE WHITE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
						SEPTEMBER 17, 1919			65			MONTHS DAYS		
									YRS.			HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO. MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Howard			MD.		
10. CITY OR TOWN OF DEATH Columbia			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5681 Harpers Farm Rd. #E			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEER (RET)			12b. KIND OF BUSINESS OR INDUSTRY WESTINGHOUSE					
13a. STATE MARYLAND			13b. COUNTY HOWARD			13c. CITY OR TOWN COLUMBIA			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 5681 HARPERS FARM ROAD 21044		
14. FATHER'S NAME HOWARD			15. MOTHER'S MAIDEN NAME RENSHAW ROSE MARIE ORENDOFF											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. /////////			17. INFORMANT (WIFE) MRS. AVIS S. RENSHAW			ADDRESS SAME AS #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>		
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Renal cell carcinoma (metastatic)</u>												> one year		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
(c) <u></u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>1977</u> to <u>9/3 1985</u> , that (I) (we) last saw the deceased alive on <u>8/8 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>H. Stahl MD</u>			22c. DATE SIGNED <u>9/14/85</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. Stahl, MD for R. Smith, MD			22e. ADDRESS Columbia Med. Plan											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE SEPTEMBER 16, 1985			23c. NAME OF CEMETERY OR CREMATORIAL MEADOWRIDGE MEM PARK			23d. LOCATION CITY OR TOWN ELKRIDGE			COUNTY STATE HOWARD MARYLAND		
24. FUNERAL DIRECTOR NAME A. B. Moore			25a. DATE REC'D BY REGISTRAR SEP 17 1985						25b. REGISTRAR'S SIGNATURE					
SINGLETON FUNERAL HOME GLEN BURNIE, MARYLAND														



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2, 7 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FARM PAGE 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 6 AND 7 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

266083

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

26040

REG. NO.

1 - STATE REGISTRAR		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 9-10-85 19										2b. HOUR M			
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE			LAST			MONTH DAY YEAR		2d. HOUR M		
		EDWARD			R.			SANDERS			9-10-85 19		11:55 PM		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR		2d. HOUR M	
Male		Black		3/28/16		69 yrs						9-10-85 19		11:55 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County	
S.C.		USA													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Columbia		Old Annapolis Rd. RT. 103										Longshoreman			
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Columbia		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5502 Waterloo Rd. 21045							
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST					
Bourrough				Sanders		Matilda				Sanders					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. W.W. 2		17. INFORMANT Gwendolyn Sanders				ADDRESS 5502 Waterloo Rd.					
				243-10-8686								Columbia, Md 21045			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY (HEAD ONLY) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) 19		21d. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)													
22a. I certify that I took charge of the remains described above and death resulted from <input type="checkbox"/> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Actual Signature Dennis F. Smyth, M.D.														TITLE (SPECIFY) Assistant M.D. MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT)														DATE SIGNED 9-11-85	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/14/85		23c. NAME OF CEMETERY OR CREMATORIAL Crestlawn Cem.		23d. LOCATION CITY OR TOWN Sykesville		COUNTY		STATE		Md			
24. FUNERAL DIRECTOR NAME Chas. A. Rice FSPA		ADDRESS 1300 Eutaw Place		25a. DATE REC'D. BY REGISTRAR SEP 19 1985		25b. REGISTRAR'S SIGNATURE									
(VR AT MS ME (5))															

620-303

1968
MOTOROLA



259175

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 6 0 4 1

REG. NO.

1 - FOR
STATE
REGISTRAR

I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
EDNA ANNA SCHOPPER						9/7/85				8:30AM		
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR			IF UNDER 24 HRS			
Female	Cauc.	MONTH	DAY	YEAR	69	MONTHS	DAYS	HOURS	MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Md.	USA				Howard County							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Laurel	7996 Aladdin Drive					housewife			-			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE						
Md.	Howard	Laurel				7996 Aladdin Drive, Howard County, Md. 20707						
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			17. INFORMANT			ADDRESS		
Walter E. Kollinger				Anna M. Talley			Stephen Slitzer, 7606 Bradshaw Rd.			Kingsville, Md. 21087		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No	-		213-52-8055	Metastasized colon carcinoma								
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)												
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on 9/1 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE	DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED					
Dr. Stephen Glasser	MA						9/10/85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS											
Dr. Stephen Glasser	600 Reisterstown Rd., Suite 512											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN	CITY		COUNTY		STATE		
Burial	9/10/85	Gardens of Faith			Baltimore	Md.						
24. FUNERAL HOME NAME	ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Schimunek Funeral Home, Inc.				SEP 13 1985			John H. Henderlite					
9705 Belair Rd., Baltimore, Md. 21236												

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 4 and 5 may be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certifying physician must be retained by the hospital or attending physician.

③

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be retained by the hospital or attending physician and sent to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8526042
1 - STATE REGISTRAR LUCY C. SCZERBICKI			REG. NO.							
DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2d. HOUR		
Lucy	C	Sczerbicki		9/16/85				7:15 A.M.		
3 SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	IF UNDER 24 HRS					
Female	White	Month Day Year July 27, 1896	89	YRS	MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH							
Pennsylvania	USA		Howard County							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY	
Columbin	Howard County General			Homemaker					Own Home	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE					21043 3105 Evergreen Way	
MD	Howard	Ellicott City								
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME	FIRST	MIDDLE	LAST			
	John		Snyder	Anna	Mary		Schettig			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS							
No	212-56-3207	Ronald Sczerbicki	3105 Evergreen Way Ellicott City, Md. 21043							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Acute myocardial Infarction										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) N/A										
19a. DATE OF OPERATION N/A	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> AT WORK N/A	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/16/85 to 9/16/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 9/16/85
22b. SIGNATURE William Flowers MD										DEGREE
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm Flowers MD					ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22e. DATE SIGNED 9/16/85		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					23b. DATE 9/19/85	23c. NAME OF CEMETERY OR CREMATORIAL Moreland Memorial Park	23d. LOCATION CITY OR TOWN Baltimore	COUNTY	STATE Md.	
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A. 5555 Twin Knolls Road, Columbia, Md. 21045					25a. DATE REC'D. BY REGISTRAR SEP 18 1985					25b. REGISTRAR'S SIGNATURE Davidson-Randall

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 6 0 4 3

REG. NO.

1 -
FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST KENNETH	MIDDLE PAUL	LAST SILVERBERG	2a. DATE OF DEATH SEPTEMBER 19, 1985	MONTH SEPTEMBER	DAY 19	YEAR 1985	2b. HOUR 10 P.M.	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH JULY DAY 3, 1976 YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 9 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) FLORIDA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY		MD.			
10. CITY OR TOWN OF DEATH ELLIOTT CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4317 SNOWDROP CT. 21043		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STUDENT		12b. KIND OF BUSINESS OR INDUSTRY SCHOOL					
13a. STATE MARYLAND		13b. COUNTY HOWARD		13c. CITY OR TOWN ELLIOTT CITY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4317 SNOWDROP CT. 21043			
FATHER'S NAME FIRST LAWRENCE		MIDDLE SILVERBERG		15. MOTHER'S MAIDEN NAME ROSALIE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-02-1705		17. INFORMANT DR. LAWRENCE SILVERBERG 4317 SNOWDROP CT.		ADDRESS ELLIOTT CITY, MD 21043		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Brain + tremor</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. DUE TO, OR AS A CONSEQUENCE OF (c)</p> <p>PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)</p>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Luke</i>		22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED SEP 24 1985							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. LUKE KAO		22e. ADDRESS 11055 Little Patuxent Pkwy Columbia MD 21046									
23a. BURIAL, CREMATION, REMOVAL (SPECIES) BURIAL		23b. DATE 9/22/85		23c. NAME OF CEMETERY OR CREMATORIAL OHEB SHALOM MEM. PARK		23d. LOCATION REISTERSTOWN BALTIMORE MARYLAND					
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC.		ADDRESS 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215		25a. DATE REC'D. BY REGISTRAR SEP 24 1985		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon paper. Pages 1 and 2 may be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 may be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 85 26044
1. FOR STATE REGISTRAR					
1. DECEASED NAME (TYPE OR PRINT)		FIRST WARREN	MIDDLE A	LAST SOUDER	2d. DATE OF DEATH MONTH DAY YEAR 9 28 85
3. SEX Male		4. RACE White		5. DATE OF BIRTH October 9, 1926	6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS
7a. BIRTHPLACE Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		7c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. BALTIMORE CITY OR COUNTY OF DEATH Howard
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10558 Leishear Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) self-employed
13a. STATE Maryland		13b. COUNTY Howard	13c. CITY OR TOWN Laurel	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 10558 Leishear Road 20707
14. FATHER'S NAME FIRST Edgar		MIDDLE Souder	LAST	15. MOTHER'S MAIDEN NAME FIRST Ada	MIDDLE Cook
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR ORDATES) WV 2 214 20 6121		17. INFORMANT Susan C. Souder same as above	ADDRESS
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC ADENOCARCINOMA OF COLON					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DUE TO, OR AS A CONSEQUENCE OF (b) _____					
DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. PLEURAL EFFUSION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II) _____	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET	CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from SEP , 19 84 , to SEP , 19 85 , that (II) (we) last saw the deceased alive on SEP , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE St. Michael		DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 9/29/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ESMACHADO		22e. ADDRESS 321 PRINCE GEO ST LAUREL MD			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE Oct 1, 1985	23c. NAME OF CEMETERY OR CREMATORIAL Emmanuel Cemetery	23d. LOCATION CITY OR TOWN Scaggsville, Maryland	
24. FUNERAL DIRECTOR Donaldson Funeral Home, Laurel, Md		25a. DATE REC'D. BY REGISTRAR OCT 01 1985 25b. REGISTRAR'S SIGNATURE J. K. Donaldson			

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NO HOSPITAL OR ATTENDING PHYSICIAN: The
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

NE 8 5 2 6 0 4 5

REG. NO.

I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	REG. NO.		
WILLIAM B. STEIGERWALD, JR.								
3 SEX		4 RACE		5. DATE OF BIRTH		2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
MALE		WHITE		MARCH 26 1925		SEPTEMBER 30, 1985	1:25P.M.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8		6 AGE (IN YEARS LAST BIRTHDAY)		
Maryland		U.S.A.		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				9 BALTIMORE CITY OR COUNTY OF DEATH		
Ellicott City		8526 Mary Beth Way 21043				HOWARD COUNTY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Maryland		Howard		Ellicott City		13e. STREET ADDRESS / ZIP CODE 8526 Mary Beth Way 21043		
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME		
FIRST William			MIDDLE B. Steigerwald, Sr.			LAST Hartman		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)			16b. SOCIAL SECURITY NO (IF YES, GIVE NAME OR DATES) WW II			17. INFORMANT Edna M. Steigerwald		
16c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			16d. ADDRESS 8526 Mary Beth Way 21043					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> .								
DO TO, OR AS A CONSEQUENCE OF (b) <u>Renal cell carcinoma - metastatic</u>								
DO TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Anemia, Malnutrition, Renal Failure,</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) _____				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						22c. DATE SIGNED 9/30/85		
22b. SIGNATURE <u>Jon Minford</u> DEGREE						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jon Minford						22e. ADDRESS 10806 Hickory Ridge Road		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Cremation 10/1/85		23c. NAME OF CEMETERY OR CREMATORIAL SECURITY PROCESS Crem.		23d. LOCATION CITY OR TOWN Catonsville Balto. Md.		
24 FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. 4107 Wilkens Avenue		ADDRESS 21229		25a. DATE REC'D. BY REGISTRAR OCT 2 1985		25b. REGISTRAR'S SIGNATURE <u>John Minford</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate may be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner may be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 85 26040		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR 145 P M		
STRIEBINGER, Louis J						September						
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		# UNDER 24 HRS		
MALE		White		MONTH	DAY	YEAR	77	YRS.	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY MD.						
10. CITY OR TOWN OF DEATH COLUMBIA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOWARD COUNTY GENERAL HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY School						
13a. STATE MD		13b. COUNTY HOWARD		13c. CITY OR TOWN COLUMBIA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6200 G FORELAND GARTH 21045				
14. FATHER'S NAME FIRST		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. Yes 219125333		17. INFORMANT		ADDRESS						
				Mrs. Selma Striebinger - Same as #13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour		
DO TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL ISCHEMIA										1 hour		
DO TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic CARDIAC Disease										Years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Cerebrovascular accident, Chronic renal failure												
19a. DATE OF OPERATION NONE		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) NONE								
21d. INJURY OCCURRED WHITE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) NA		21f. LOCATION STREET NA		CITY OR TOWN	COUNTY	STATE				
22a. I certify that (this hospital) attended the deceased from AUGUST 5 19 85 to SEPT 2 19 85, that (we) last saw the deceased alive on SEPT 2 19 85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (we did) (did not) view the body after death.										22c. DATE SIGNED 9-2-85		
22b. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM PARNES		22c. DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 9/2/85		23c. NAME OF CEMETERY OR CREMATORIAL 11085 LITTLE PATUXENT PKWY COLUMBIA MD 21044		23d. LOCATION CITY OR TOWN		COUNTY		STATE		
24. FUNERAL DIRECTOR NAME Anatomy Board		ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR SEP 06 1985		25b. REGISTRAR'S SIGNATURE						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbons pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 85 26041

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
FRANCIS R TOOLE						9	3	85	4A M		
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
M		CAUCASIAN	MONTH	DAY	YEAR	45	YEARS	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Pennsylvania		USA						Howard County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
COLUMBIA		HOWARD CO. GENERAL HOSP			President			Publishing			
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			21043	
MD		HOWARD	ELLCOTT CITY				8126 Wooded Glen CT				
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			ADDRESS			Silfies	
Michael		F.	Toole	Lois							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest			
No		199-30-6442			Mrs. Valerie M. Toole - Same as #13			DUE TO, OR AS A CONSEQUENCE OF (b) Cardiogenic shock			
								DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial ischemia			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b											
None		19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from Nov. 10, 1980, to SEPT 3, 1985, that (I) (we) last saw the deceased alive on SEPT 3, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not see the body after death.											
22b. SIGNATURE William Parnes		22c. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 9-3-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM PARNES		22e. ADDRESS 11085 LITTLE PATUXENT PKWY COLUMBIA MD 21044									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 9/3/85		23c. NAME OF CEMETERY OR CREMATORIAL CITY OR TOWN			23d. LOCATION CITY OR TOWN		COUNTY	STATE	
24. FUNERAL DIRECTOR NAME Anatomy Board		25a. DATE REC'D. BY REGISTRAR SEP 06 1985			25b. REGISTRAR'S SIGNATURE Julia Davidson-Pardella						
ADDRESS Balto., Md.											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

relinquished by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician it should be detached for use as the burial/transit permit. Then please remove carbon paper. Please sign and attach this certificate to the burial/transit permit. Then attach the burial/transit permit to the death certificate. This should be done within 24 hours after death.

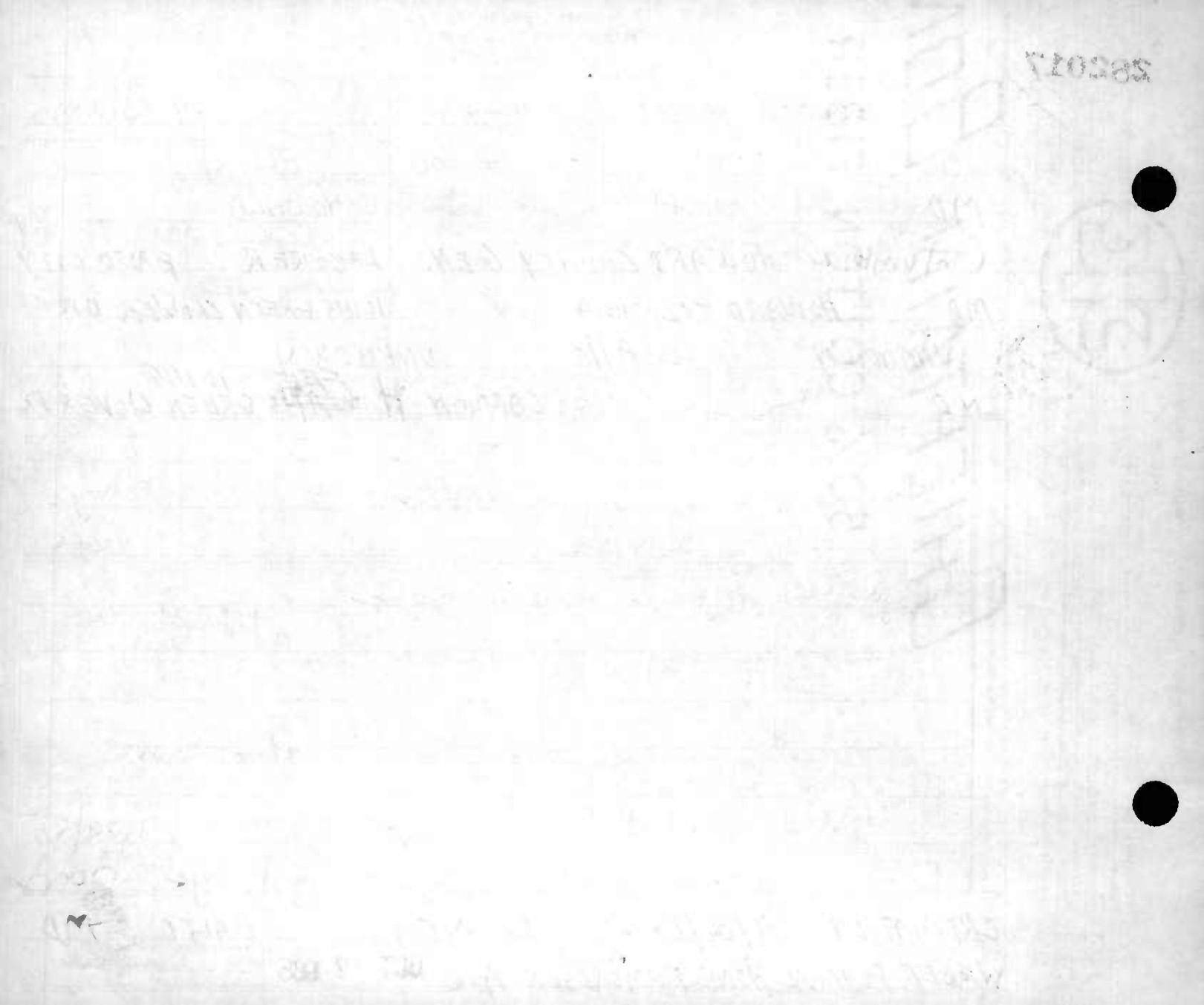
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked "died at home," attach this certificate to the death certificate.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										5 26048					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Edward Wright					WALLS	09 29 85						3:42 P M			
3. SEX			4 RACE	5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
M			white	MONTH	DAY	YEAR	80			MONTHS	DAYS	HOURS	MIN.		
7a BIRTHPLACE COUNTRY			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.			
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY						
Columbia			HOWARD COUNTY GEN.			LABORER			BALTO CITY						
13a STATE			13b COUNTY			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS / ZIP CODE						
MD			HOWARD			YES			10145 GREEN CLEVER DR						
14 FATHER'S NAME FIRST			MIDDLE			15 MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST			
UNKNOWN			WALLS			UNKNOWN									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
NO			213030868			CARMEN H. FEATIS			10145 GREEN CLEVER DR			15 min.			
18 CAUSE OF DEATH (Enter only one cause per line for 18, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio-respiratory arrest</u>															
DUE TO, OR AS A CONSEQUENCE OF (b) <u>hypotension</u> coma													3 days		
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes</u>													years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>dehydration, organic brain syndrome</u>															
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN			COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>9/28</u> , 19 <u>85</u> , to <u>9/29</u> , 19 <u>85</u> , that (II) (we) last saw the deceased alive, on <u>9/29</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (II) (we) (initials) <u>CF</u>															
22b. SIGNATURE <u>CF</u> DEGREE													22c DATE SIGNED <u>9/29/85</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
CF. Sheehan MD.			10802 Hickory Ridge Road												
23a BURIAL, CREMATION, REMOVAL			23b. DATE			23c NAME OF CEMETERY OR CREMATORIAL			23d LOCATION CITY OR TOWN			COUNTY STATE			
CREMATION			9/30/85			WESTVIEW MEM.			BALTO			MD.			
24 FUNERAL DIRECTOR NAME			ADDRESS			25a DATE REC'D. BY REGISTRAR			25b REGISTRAR'S SIGNATURE						
WEBER FUNERAL HOME EDMONDSON AVE.			5331			OCT 7 1985			Weber-Funeral Home						

110985



GILDED MORNINGS RECALLS THE INNOCENCE OF YESTERDAY'S MAINTAINING AND 31201

7/84
5M

BP _____

DHMH - 17
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE WRITE THE WORD "PENDING" IN REINEL IN ITEM 1, FIVE EIGHT S 1, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM P.M. 3, RETAIN PAGE 5 FOR YOUR FILE. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

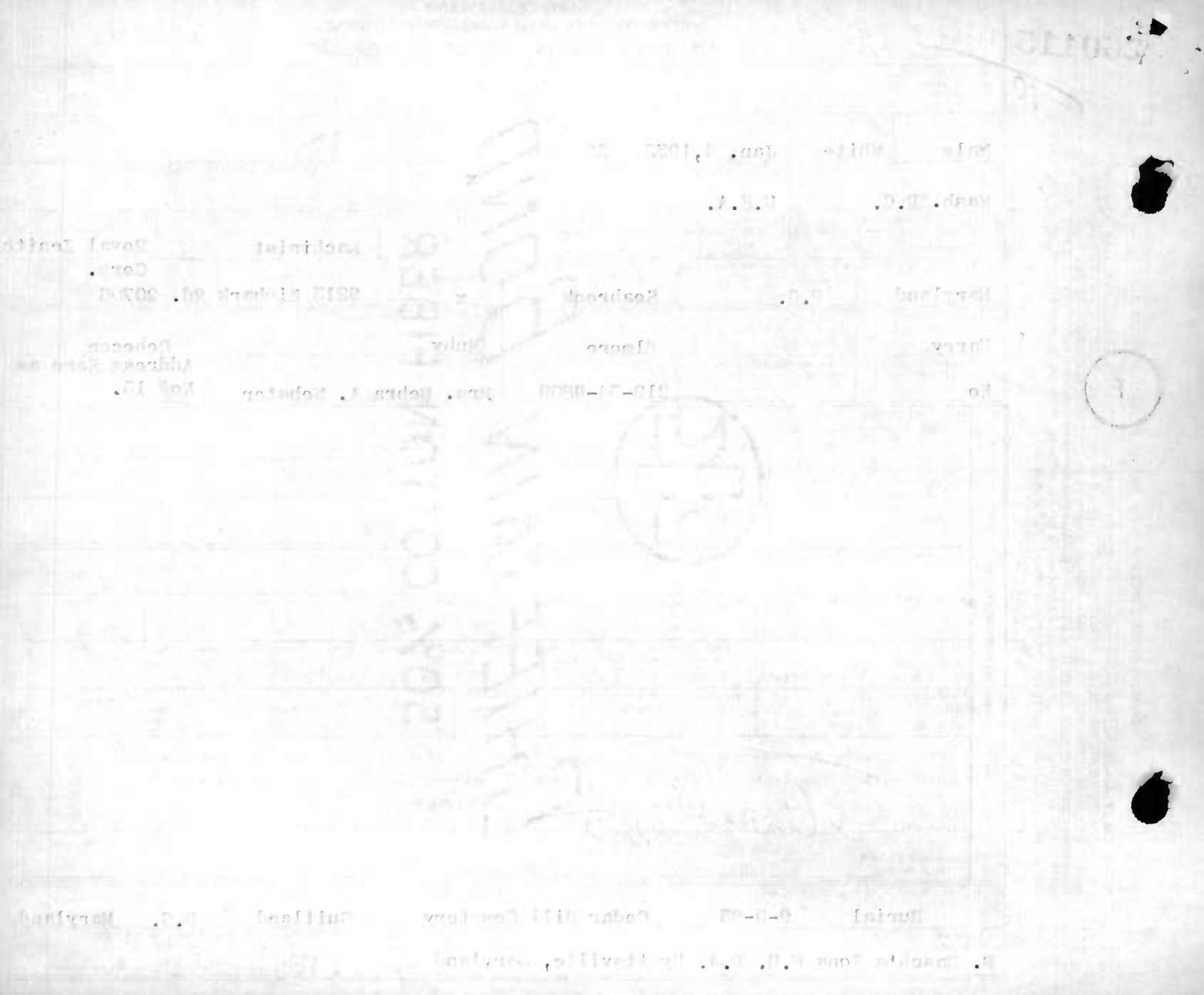
**1 - STATE
REGISTRATION**

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

26049
REG. NO.

REG. NO.

DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	REG. NO.		
Michael Alva Webster								
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2a DATE KNOWN OF ESTI- DEATH MATED		
Male	White	Jan. 4, 1953	32 yrs.			<input checked="" type="checkbox"/> MONTH 9 <input type="checkbox"/> DAY 719 <input type="checkbox"/> YEAR 85		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD		
Wash. D.C.		U.S.A.				9. BALTIMORE CITY OR COUNTY OF DEATH		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Jessup		Rt. 1 near Rt. 32			Machinist		Royal Zenith Corp.	
13a STATE		14b COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS	13f. ADDRESS		
Maryland		P.G.	Seabrook		9213 Kimbark Rd.	20706		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Harry Elmore			Ruby					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT		
No			219-54-9809			Mrs. Debra A. Webster		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 8120 IMMEDIATE CAUSE (a) Transected thoracic aorta Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (b) } DUE TO, OR AS A CONSEQUENCE OF (c) }								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:56xx 9 7 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver in auto/auto impact			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET Rt. 1 nr. Rt. 32		CITY OR TOWN Jessup	COUNTY Howard	STATE MD
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Thomas D. Smith, M.D.</i> TITLE (SPECIFY) M.D. MEDICAL EXAMINER								
DATE SIGNED 9/7/85								
EXAMINER'S NAME (TYPE OR PRINT)			Thomas D. Smith, M.D. ADDRESS 111 Penn St. Baltimore MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 9-9-85	23c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN Suitland	23e. COUNTY P.G.	23f. STATE Maryland	
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Maryland			25a. DATE REC'D. BY REGISTRAR SEP 11 1985			25b. REGISTRAR'S SIGNATURE <i>Lia Swanson Pendall</i>		



266059

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in the hands of a physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 1 and 2 should be retained for use at the burial permit. Then please remove certifying papers. Page 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner will be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3526050		
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 9 13 85							2b. HOUR 5 ⁴⁴ PM		
1. DECEASED NAME (TYPE OR PRINT) EDMUND			FIRST Edmund	MIDDLE G.	LAST Whitehead							
3. SEX Male			4. RACE Caucasian			5. DATE OF BIRTH MONTH 7 DAY 10 YEAR 09		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS			IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. 0	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD			
10. CITY OR TOWN OF DEATH COLUMBIA			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOWARD County GEN Hosp			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrical Engineer			12b. KIND OF BUSINESS OR INDUSTRY US Gov't.			
13a. STATE MD			13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 5111 Allan Road/ 20816		
14. FATHER'S NAME FIRST Edmund			MIDDLE W.	LAST Whitehead		15. MOTHER'S MAIDEN NAME FIRST Ethel			LAST Ourand			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WW II 577-05-0666			17. INFORMANT Marion J. Whitehead, Same address as #13.			ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))			<i>Coronary Arrest</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			DUE TO, OR AS A CONSEQUENCE OF (b) <i>Respiratory Failure</i>									
			DUE TO, OR AS A CONSEQUENCE OF (c) <i>neuroleptic Extrusive Dystrophy</i>						3499			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>EDRlich Cardiopulm. Arrest</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8-29-1985 , to 9-12-1985 , that (I) (we) last saw the deceased alive on 9-12-1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>A. Poller, M.D.</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8-13-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) AJ Poller, M.D.			22e. ADDRESS 5216 Bryant Rd. Columbia, MD 21046									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/17/85		23c. NAME OF CEMETERY OR CREMATORIAL Middleburg Memorial Cem.		23d. LOCATION CITY OR TOWN Middleburg COUNTY Virginia						
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 Wisconsin Ave., NW, Washington, D.C. 20016			25a. DATE REC'D. BY REGISTRAR SEP 10 1985			25b. REGISTRAR'S SIGNATURE <i>John K. Johnson</i>						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached from the burial permit. Then please remove carbon paper. Page 1 end. 2 should be detached from the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Name 2 is married or Name 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 6526051	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
EVA M. WINKLER						September 12, 1985						4 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH June 15, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 70			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County							
10. CITY OR TOWN OF DEATH Fulton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12490 Limekiln Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Physicist Ph.D			12b. KIND OF BUSINESS OR INDUSTRY Retired						
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Fulton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 12490 Limekiln Road		13f. LAST			
14. FATHER'S NAME FIRST August		MIDDLE Brandt		15. MOTHER'S MAIDEN NAME FIRST Gertrude									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579 44 9629		17. INFORMANT Elaine C Patico		ADDRESS 5448 Hound Hill Ct Columbia		21045					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Primary Cancer liver DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Squamous cell cancer colon recto - mouth													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) this hospital attended the deceased from 1979 to Sept. 12 1985 , that (I)(we) last saw the deceased alive on Sept. 7 1985 , and that in (my)(our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.												22c. DATE SIGNED 9/12/85	
22b. SIGNATURE <i>Lewis Kellert, MD</i>		22d. DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis Kellert, MD		22f. ADDRESS 4000 OLNEY LAYTONSVILLE Rd. OLNEY MD 20832											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Sept 13, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Westview Memorial Pl.		23d. LOCATION CITY OR TOWN Catonsville Balto., Md.		COUNTY		STATE			
24. FUNERAL DIRECTOR NAME Harry H Witzke		ADDRESS 4112 Columbia Rd Ellicott City		25d. DATE REC'D. BY REGISTRAR SEP 16 1985		25b. REGISTRAR'S SIGNATURE <i>John Smith</i>							

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